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G-37

Standing Committee on General Government

Comité permanent des affaires gouvernementales

Strengthening Quality and Accountability for Patients Act, 2017

Loi de 2017 renforçant la qualité et la responsabilité pour les patients

2nd Session
41st Parliament

Monday 20 November 2017

2e session
41e législature

Lundi 20 novembre 2017

Chair: Grant Crack
Clerk: Sylwia Przezdziecki

Président : Grant Crack
Greffière : Sylwia Przezdziecki

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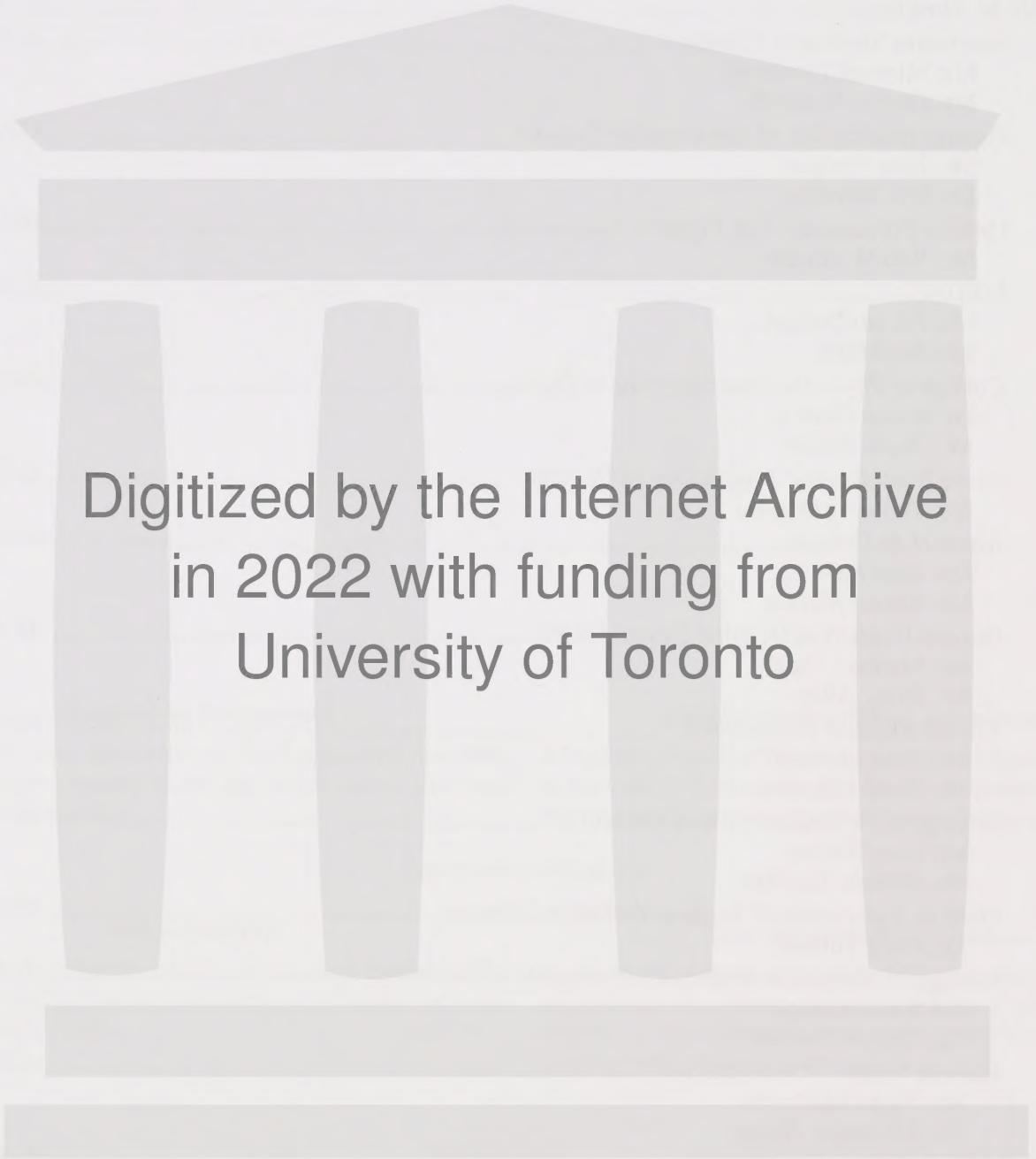
CONTENTS

Monday 20 November 2017



LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

Monday 20 November 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Lundi 20 novembre 2017

The committee met at 1400 in room 151.

STRENGTHENING QUALITY AND ACCOUNTABILITY FOR PATIENTS ACT, 2017

LOI DE 2017 RENFORÇANT LA QUALITÉ ET LA RESPONSABILITÉ POUR LES PATIENTS

Consideration of the following bill:

Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients / Projet de loi 160, Loi visant à modifier, à abroger et à édicter diverses lois dans le souci de renforcer la qualité et la responsabilité pour les patients.

The Chair (Mr. Grant Crack): Good afternoon everyone, members of the committee, Clerk, support staff here with us, and staff from the ministry. I would like to call the Standing Committee on General Government to order.

Today, we're here to deal with public hearings on Bill 160, An Act to amend, repeal and enact various Acts in the interest of strengthening quality and accountability for patients.

We have a very, very tight schedule, right till 6 o'clock. Every presenter has up to five minutes for their presentation, followed by up to nine minutes. I'm going to have to keep everything on cue.

INNOVATIVE MEDICINES CANADA

The Chair (Mr. Grant Crack): At this point, I would like to invite Innovative Medicines Canada. We have the chair of the board, Mr. Michael Tremblay, as well as Vice-President Declan Hamill, this afternoon. We welcome you. As you get ready, just a reminder that room 2 that way is the overflow. There is a TV there and people can wait and listen to the proceedings, so committee room 2 down the hall. Having said that, the floor is yours, gentlemen. Thank you for coming.

Mr. Michael Tremblay: Mr. Chairman, thank you. Good afternoon. My name is Michael Tremblay and I am the president of Astellas Pharma Canada, based here in Markham. It's my great pleasure to be speaking to you today in my role as chair of Innovative Medicines Canada, or IMC. I am joined here by Declan Hamill, our vice-president of legal, regulatory affairs and compliance.

IMC is the association representing Canada's innovative biopharmaceutical sector, a community of companies committed to discovering, developing and delivering medicines and vaccines that extend life, improve health and alleviate pain. Our 45 members support more than 30,000 jobs across the country, more than half of which are in this great province.

I am also proud to represent an association that has been governed by a comprehensive, robust and authoritative code of ethical practices, which sets out our core ethical values. Adherence to this code is a condition of membership in our association.

I would like to share some comments on Bill 160, an act that has among its goals a proposal to inject additional transparency into the transfer of value between the private sector and health care practitioners. IMC will share more detailed and substantive thoughts on this subject with the committee in writing in the coming days. In the meantime, I would like to offer three key points for your consideration.

First, IMC believes that any transparency framework introduced by the government of Ontario must be inclusive and comprehensive. IMC believes that a meaningful transparency framework must encompass and include the widest array of commercial sectors, including both innovative and generic drug manufacturers, medical technology companies, software and IT firms, and any other commercial interest transferring value into the health care system. To take any other approach would provide only partial transparency and raise the question as to why any industry players were excluded while others are subject to a significant compliance burden.

Similarly, we believe that the framework should apply to all regulated health professions. As scopes of practice evolve and expand to adapt to changing health care challenges, physicians should be only one of the professions covered by any forthcoming framework, along with nurses, pharmacists and others.

Second, IMC believes that any transparency framework should be implemented at the pan-Canadian level. Although health care is administered by the provinces and the territories, there has been an admirable focus in recent years on harmonizing regulations, aligning policies and coordinating programs across the country. Prior to implementation, we would strongly urge the government of Ontario to work with industry and colleagues

gathered around the table at the next FPT health ministers' meeting to ensure that whatever framework is ultimately implemented bears a made-in-Canada stamp. Failing to work at a pan-Canadian level would create a patchwork quilt of multiple provincial policy frameworks, increasing the cost and time required for compliance.

Third, IMC believes that any transparency framework introduced by the government of Ontario should be as simple, as clear and as reasonable as possible. IMC has been observing the experience of other nations that have launched their own transparency initiatives over the past decade. Many of these models share several problematic attributes. They disclose incomplete, inaccurate or context-free information that undermines trust in the health care system and its practitioners. They fail to categorize different kinds of value transfers, and lump multiple diverse interactions into a single number. They create costly and complex systems that provide ongoing administrative and technology challenges to the very governments that created them. These outcomes must be avoided at all cost.

In conclusion, IMC strongly believes that the process of discovering, developing and delivering innovative medicines and vaccines to patients, health care practitioners and health care systems cannot happen in isolation. Our work touches dozens of stakeholders, from patients, doctors, nurses and pharmacists to policy-makers, payers and regulators. We share invaluable insights, advice and recommendations as we work to bring new medicines and vaccines to patients across Canada.

As health care problems become ever more complex, and as provinces like Ontario struggle to balance infinite demands with finite resources, we would strongly caution the Legislature to avoid implementing a policy framework that could undermine, complicate and impede the solutions that we're all committed to creating.

Thank you.

The Chair (Mr. Grant Crack): Thank you very much, sir.

We'll start with the official opposition. Mr. Yurek?

Mr. Jeff Yurek: Thank you for being here, gentlemen. Just a couple of questions for you that maybe you can focus on for me.

With other jurisdictions that have passed these types of laws, usually it's the state government that has paid for the website and releases the data. Can you tell me what the costs would be for the government to create this type of portal? Do you know?

Mr. Michael Tremblay: It really depends on the level and complexity of the asks. The granularity of the data would obviously dictate the cost of the system. We haven't taken a look at trying to cost this out from our end, as individual companies, because we're trying to figure out what the requirements are. Once we have the requirements, we should be able to better formulate a cost.

Mr. Declan Hammill: I would just add that one of the challenges we face at the moment with the bill is that many of the details that would allow us to make those calculations and come up with implementation mechanisms are not there. They will be in the regulations which follow the bill. So it's very challenging for us at the moment to look at this aspect of Bill 160 to see how it will work in practice.

Mr. Jeff Yurek: I'm concerned because I haven't really been able to flesh out what the costs are going to be at the end of the day. If you look at what has happened with eHealth, we're at $8 billion and we still have no endgame at the end of the day. So it's a large concern of mine.

My other question is, with regard to clinical trials, doctors are paid for their time to investigate new drugs that impact their patients. Is this type of reporting going to affect doctors' involvement in clinical trials in the future?

Mr. Michael Tremblay: If a requirement is to disclose that, it certainly could. My humble opinion would be that from a clinical trials perspective, centres of excellence will always be centres of excellence, but if all else was equal, they could certainly look to other jurisdictions. Given the fact that this is the only province that currently has this tabled, it could, in fact, sway the movement of clinical trials to other areas.

Mr. Jeff Yurek: It's concerning. What about the threshold amounts? What level do you think it should be put at? I heard that in the States, it's somewhere around $10. What do you think?

Mr. Michael Tremblay: I think the first question with that is really to understand what the desired outcome is. What is it that the government is hoping to achieve? Then you can decide what that threshold is.

Mr. Jeff Yurek: Any idea of what exactly should be included in that reporting? Should it just be financial payments, or other items?

Mr. Michael Tremblay: The value transfer is really the definition, and I think that's going to dictate what that definition is. Again, we don't know what the definition of "transfer of value" is at this point in time.

Mr. Jeff Yurek: Thanks.

The Chair (Mr. Grant Crack): We'll move to Madame Gélinas, from the NDP.

1410

M^me^ France Gélinas: Thank you so much for coming. I was under the impression that you were supportive of what the government had put forward. Am I wrong?

Mr. Michael Tremblay: We're supportive of transparency, absolutely. It's hard for us to really understand the exact level of detail that they would like to see out of it.

M^me^ France Gélinas: All I can tell you is that, if there's something that is important for you to put in, don't wait till regulations. Tell us now, and we will try to include it. I have waited for regulations on other bills and lived to regret it every day of my life.

Would you support putting in the value for samples left behind? New medication—you go meet with the physician, the nurse practitioner, whatever, and you leave

samples behind. Would you see this as included in the value transfer?

Mr. Michael Tremblay: Again, depending on what it is you're trying to achieve, it could very well—

M^me^ France Gélinas: I have no idea what the government wants to achieve. They have not shared that with us.

Mr. Michael Tremblay: If we understood that better, I could probably be in a better position.

M^me^ France Gélinas: We're in the same boat.

You were very clear that depending on how we do this, we could severely undermine the trust. We fully understand that if you want quality care, there has to be a trusting relationship; otherwise, you don't have quality care.

Are there any jurisdictions out there that do this transparency of value transfer well, and what did they achieve?

Mr. Declan Hammill: I don't know if I can point to one model jurisdiction. We have found that there have been aspects of the US system's so-called sunshine act which have some advantages in the sense that at least what is a transfer of value and some of the key definitions are very clear, and therefore it's easier to understand. Some of the questions that might be answered in regulation are within the sunshine act.

That said, the threshold for disclosure in the sunshine act is very low. So I don't know if there is one model that we can point to and say, "That's the way you should do it, because it works very well there."

At the end of the day, some kind of made-in-Canada approach is what we would advocate for, as Mike said. We are concerned about the possibility of having multiple different disclosure regimes across Canada. We don't think that will serve anyone's interests.

M^me^ France Gélinas: We don't have control over this. We only control Ontario.

Mr. Declan Hammill: Absolutely. I agree.

M^me^ France Gélinas: Could you think of a good reason why we should do this? You say there are dangers in doing this if it's not done right. It has to be done right for whatever the government wants to do. Why would we want to do this? What can be achieved through this?

The Chair (Mr. Grant Crack): I apologize. We don't have time for that. I have to keep right on today.

Mr. Rinaldi, from the government.

Mr. Lou Rinaldi: Thank you so much for being here today and for your succinct presentation.

Transfer of value will be posted publicly on a searchable Internet database that will show the names of medical industry firms that provide the payment as well as the names of recipients. Can you elaborate on how this database will help patients make informed decisions about their health care?

Mr. Michael Tremblay: I'm not sure that we would be in a position to make that decision. I think it's really the government deciding whether or not—that's what they're hoping, that this is going to happen. If you ask me, would I go onto that database and take a look, perhaps I would. I'm not convinced, as a patient, that I would do something like that, but that's my own personal opinion.

Mr. Lou Rinaldi: That's why we're having these hearings.

You did speak publicly about the bill when it was first introduced. Can you speak to why increased transparency in the health care system is so important?

Mr. Michael Tremblay: Transparency, in general, is an important thing. Obviously, as it stands right now, health care practitioners and physicians disclose. They have to disclose any relationships that they would have with companies. So it's a step in the right direction.

I think the interesting part of the proposal here is that you've actually expanded the base of people who may have to disclose, and I think that makes sense—in addition to not just pharmaceutical companies, but, really, across the board. This is a little bit different than some of the other jurisdictions that we've seen so far.

Mr. Lou Rinaldi: Thank you so much.

The Chair (Mr. Grant Crack): Thank you to the both of you for coming before committee this afternoon. It's much appreciated.

ONTARIO ASSOCIATION OF NATUROPATHIC DOCTORS

The Chair (Mr. Grant Crack): Next on the agenda we have the Ontario Association of Naturopathic Doctors. We have the chief executive officer, the government and regulatory affairs manager, and an OAND expert and naturopathic doctor. I'll let you introduce yourselves as you speak. The floor is yours. You have up to five minutes.

Mr. John Wellner: Thank you, Mr. Chair, and esteemed members of the committee. Good afternoon. My name is John Wellner. I'm the CEO of the Ontario Association of Naturopathic Doctors. With me is Dr. Eric Marsden, a naturopathic doctor from Vaughan. Thank you for the opportunity to present to you today on behalf of our members.

We understand that it is the intent of Bill 160 to improve the quality and effectiveness of health care. We are also aware that any amendments to this bill would require all-party support, but we think it's important to the patients of Ontario to raise two important issues related to what you have before you.

The first is in reference to the reporting and treatment of diseases of public health significance. Since Bill 160 proposes changing the term "reportable disease" to "disease of public health significance," we believe it appropriate to address a shortfall in this legislation related to the reporting of these diseases themselves. Section 25 of the Health Protection and Promotion Act refers to the duty of a practitioner to report a disease of public health significance to the medical officer of health. It reads:

"Duty to report disease

"25(1) A physician or" other practitioner, including naturopaths, "forms the opinion that the person has or

may have a reportable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided."

It is clear from the legislation that naturopaths in Ontario have the duty to report. Unfortunately, naturopaths are prevented under the law from using the only means available to actually determine whether a patient has a reportable disease; that is, a lab test.

A naturopath may suspect a disease of public health significance, but is not currently permitted to order a laboratory test to confirm this suspicion. Furthermore, it is out of a naturopath's scope of practice to treat a reportable disease such as measles, gonorrhea, pertussis or tuberculosis. Naturopaths have to refer patients with such diseases to a physician or a nurse practitioner for treatment—and we want to do this—but without a lab test, it is all guesswork and the patients may not get treated.

Potentially infectious patients are sent back into their communities to their families, to their co-workers, to those with whom they may ride public transit or to sit in another practitioner's waiting room with other potentially vulnerable patients who can be infected, or maybe they decide that they don't want to see a physician and get the test at all.

Naturopaths want to partner in the protection of public health and collaborate with our RHPA practitioners for their patients' health, but there is a regulatory barrier. If naturopaths are required by law to report a disease of public health significance and refer treatment, it is only logical and in the interests of public health to lift the restrictions that prevent them from ordering the test that allows them to do this.

The second issue is in reference to the Nursing Act. We believe that there is an oversight in the act based on the fact that it was written prior to the Naturopathy Act, 2007, and that it doesn't take the Naturopathy Act into account. The issue is about the delegation to nurses, but not those in the extended class.

Section 4 of the Nursing Act outlines "authorized acts." Section 5 of the act describes additional requirements for these authorized acts. Section 5(1) reads:

"5(1) A member shall not perform a procedure under the authority of section 4 unless,

"(a) the performance of the procedure by the member is permitted by the regulations" or by delegation, which is outlined in section 5(1)(b) and reads: "by a person who is authorized to do the procedure by ... the Chiropody Act, 1991, the Dentistry Act, 1991, the Medicine Act, 1991 or the Midwifery Act, 1991."

Although the Naturopathy Act, 2007, gives naturopaths the authority to perform the authorized acts outlined here, because it wasn't proclaimed until 2015, the ability to delegate these acts to nurses is absent from the Nursing Act.

Our request is a simple fix of adding the Naturopathy Act, 2007, to the list of acts in section 5(1)(b) of the Nursing Act. We wish to collaborate with our noble and hard-working RHPA partners in nursing and are not attempting to create additional hierarchy here, but we do believe that nursing jobs would be created and patients would be better served if naturopaths were permitted to delegate to nurses.

1420

To summarize, even though we are required to report diseases of public health concern, there is no way for a naturopath to do so properly. We are asking you to strengthen our link in the net that catches these diseases, protects the public and serves patients. We are also asking for a three-word amendment to the Nursing Act that would allow naturopaths to delegate authorized acts to nurses.

Thank you for your time today. I and Dr. Marsden would be happy to take any questions you may have.

The Chair (Mr. Grant Crack): Thank you very much. You're just within time. We appreciate it.

Madame Gélinas, from the NDP.

M^me^ France Gélinas: Would you know, in other jurisdictions, as in other provinces, if any of the naturopathic doctors are allowed to order those tests?

Mr. John Wellner: Yes. BC would be an example.

M^me^ France Gélinas: BC would be an example where they are allowed?

Mr. John Wellner: Absolutely.

M^me^ France Gélinas: Would there be a specific list of tests that you could ask for?

Mr. John Wellner: I think what we are talking about are those diseases that are communicable or of public health interest—that is, essentially, diseases that are infectious and that put the public health at risk. We are hoping to ensure that there is quick diagnosis facilitated through what we're asking, and also the protection of those who are the contacts of those patients.

M^me^ France Gélinas: If I switch to the Nursing Act, the same first question: Are there any jurisdictions where naturopathic doctors are included in the list of people who can delegate acts to nurses?

Mr. John Wellner: Do you want to do this, Dr. Marsden?

Dr. Eric Marsden: Yes. Throughout North America, in different jurisdictions where naturopathic doctors are regulated, there are several where they are able to delegate to nurses.

M^me^ France Gélinas: Any in Canada?

Dr. Eric Marsden: I'm not exactly sure. I believe BC does.

M^me^ France Gélinas: Could you give me an example of an act that you would like to delegate to a nurse?

Dr. Eric Marsden: Sure. Naturopathic doctors are able to administer substances by injection or inhalation, like an intravenous substance. Within the conventional framework, nurses are truly the experts in delivering and observing patients and treatments through intravenous infusion. This would be one simple example of how nurses could participate and probably improve care and outcomes for patients.

M^me^ France Gélinas: I could see that. Okay. Will you be coming up with specific amendments that you want us to put forward?

Mr. John Wellner: The specific amendments, yes, but we are also aware of the fact that we are addressing issues that are peripheral to what is on the table today.

M^me^ France Gélinas: You're lucky, because Bill 160 is an omnibus bill that touches almost everything. Have no fear; I will be asking for unanimous consent pretty much on everything, because this bill goes from soup to nuts.

Mr. John Wellner: You will receive a written submission as well, with wording for an amendment, yes.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Grant Crack): We'll move to the government. Mr. Rinaldi?

Mr. Lou Rinaldi: Thanks for being here today and expressing your opinions on Bill 160.

My question is fairly simple, I think. Can you speak about the transparency of the health care system, how important it is, and specifically how it relates to you?

Mr. John Wellner: I'm going to take a first stab, and maybe Dr. Marsden can weigh in quickly as well.

It is essential that RHPA practitioners work together and collaborate where possible. Many different RHPA practitioners have different scopes of practice. We have a fairly good scope of practice. But it is essential that we refer patients between us. That is what we endeavour to do, and that is, I think, what my suggestions today would suggest.

Anything else, Dr. Marsden?

Dr. Eric Marsden: I think transparency improves a patient's or, essentially, a consumer of health care's ability to make good choices. The problem sometimes with transparency in other jurisdictions is, when there is too much information, to be too overwhelmed with it to make good choices. Transparency, in a consumable way, is always an improvement for patients.

Mr. Lou Rinaldi: Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We'll move to the official opposition. Mr. Yurek?

Mr. Jeff Yurek: Thanks for coming in. Basically, on your first point, you have a duty to diagnose and treat diseases of public significance, and under this new title, probably the list is going to grow. But you can't utilize the diagnostics to actually diagnose that that is, in fact, the disease that you need to treat and report.

Mr. John Wellner: Almost. We are required in the act to report one of these diseases, but treatment is not in scope.

Mr. Jeff Yurek: Not in scope, okay.

Mr. John Wellner: So to refer to the proper treatment, and to report to the medical officer of health, currently it is guesswork, a suspicion. We think patients would be much better served if there was a diagnostic test that would assure that there was both reporting to the local public health unit and also the referral to the appropriate practitioner.

Dr. Eric Marsden: Naturopathic doctors are able to order a variety of laboratory tests as well as doing an appropriate physical history and examination. As a result of these investigations, we have a duty to refer, as appropriate, to—depending on what's occurring in a patient. However, the public health tests—these reportable diseases, as they sit right now, we are unable to do any of that testing. That could range from a patient who has whooping cough, or pertussis, to a patient who we're concerned about having H. pylori that might be creating stomach pain and an ulcer. These are just examples of where we would then have to refer for testing. There are multiple inputs into the health care system where a patient may actually have five or six contacts in various ways before they get appropriately tested. There are many examples of this within my practice where this occurs.

Mr. Jeff Yurek: So I would assume, because you can't verify it by diagnostic lab tests, you would have to refer them back to a nurse practitioner or a doctor, whom they may not be able to get to in a timely manner.

Dr. Eric Marsden: Exactly. And then they might end up in an emergency room or other areas. That's not where we want them.

Mr. Jeff Yurek: I don't know, because I haven't really talked to anyone in legal, but is it a regulation change or is it a legislative change? Do we know?

Mr. John Wellner: It is currently under regulation in the lab act. I can tell you very soon, and it will be in our reports, what exactly the regulation is: Laboratory and Specimen Collection Centre Licensing Act, regulation 682.

Mr. Jeff Yurek: So the government could change it without having to go through this door, Bill 160, right?

Mr. John Wellner: I presume.

Mr. Jeff Yurek: Have you been in consultation with the government regarding this change? What's the feedback you received?

Mr. John Wellner: We have been in consultation with the government and the feedback is, "We will continue to listen to you" and "We haven't got a particular perspective either way."

Mr. Jeff Yurek: That's more than—

Mr. John Wellner: But it's taking quite a while.

The Chair (Mr. Grant Crack): Thank you very much, Mr. Yurek, and thank you, gentlemen, for coming before committee this afternoon. I appreciate your insight.

ONTARIO PROFESSIONAL FIRE FIGHTERS ASSOCIATION

The Chair (Mr. Grant Crack): Next on the agenda, from the Ontario Professional Fire Fighters Association, we have President Rob Hyndman and Executive Vice-President Mark Train with us this afternoon, and Mr. Sobey is with us too. It's good to see you all. We welcome you to committee this afternoon. You have up to five minutes for your presentation, followed by nine

minutes of questioning from the three parties. The floor is yours, sir.

Mr. Rob Hyndman: Thank you, Mr. Chairman. My name is Rob Hyndman and with me is Mark Train. We are the president and executive vice-president of the Ontario Professional Fire Fighters Association. For the sake of time, I won't go too much into the detail about our organization. We will be having our delegates and our legislative conference here this week talking to you about us anyway.

Essentially, the evolution of our lobby on this particular file is that the idea of utilizing paramedic-firefighters in Ontario is not something new. We've been talking about this since the late 1990s when the organization voted to pursue this as a legislative issue. For the last 20 years we've been consistently talking about the advantages to municipalities for the use of firefighter-paramedics and utilizing that existing capacity.

Some of the reasons for the lobby, and some of the deficiencies that we've noted over the course of the last number of years in the current pre-hospital-care system are, essentially, pre-hospital care and EMS in the province are at a crossroads. We've seen through successive Auditor General reports the cost for land ambulance and pre-hospital care rising at a significant rate. Between the years 2000 and 2017 we have seen an approximate 223% increase in costs. One of the most recent Auditor General's reports has identified that we essentially are not sure how we're doing as a result. When we look at the balance between the taxpayer and the service, this is something where we feel the utilization of firefighter-paramedics would be able to help defer some of those costs.

1430

It's important to note that the ministry generally does not obtain information on patient outcomes, either overall or by ambulance service, to be able to truly measure what we're doing so as to determine whether or not it is effective. We are not doing a very good job of it right now.

One of the opportunities that we have is that fire stations are strategically placed around communities in Ontario, to be able to deliver emergency medical care quickly and efficiently. The emergency response system design works because patients often not only have medical needs but may also require physical rescue, protection from the elements, and the creation of a safe physical environment, as well as non-medical management of their surroundings.

Many municipal ambulance service departments have developed tiered response agreements with fire departments, and we've seen the culmination of that through the OPALS study and then moving forward since that time. It's something that we've been able to move forward with, but we would like to see it expanded.

One of our opportunities here is that we can have an improved service delivery in a cost-efficient manner and be part of the solution to the existing challenges that Ontario's current EMS system faces. We believe that one way to assist with those challenges is to amend the existing legislation to allow firefighters currently certified as paramedics to be able to practise their skill set when they arrive on a fire truck. This, we believe, is consistent with the AG's 2013 recommendation to "develop processes, such as incentives, to promote efficient ambulance service delivery—including minimum service levels or benchmarks—especially where differences exist."

Our solution builds on work being done in other jurisdictions. We see this model across Manitoba, Alberta, our eastern provinces and the vast majority of the US, with it being in over 90% of our large urban centres.

Our model suggests a change in the law to allow those firefighters who are already trained to be able to respond. In 2010, a NIST study—which is in your package—showed that a crew of three or four people could complete the critical tasks more quickly than a single-person PRU or a two-person ambulance. Modelling that we took on with PricewaterhouseCoopers, utilizing the most complete dataset that we could find at the time, which was the Niagara master EMS plan done by Pomax, shows that the utilization of firefighter-paramedics in the community can have an impact on efficiencies through EMS calls being cancelled, and significant cost savings and future cost avoidance from utilizing the firefighter-paramedic resource.

Working together, the provincial government and Ontario municipalities can provide an interagency dual response that provides an efficient and effective response to medical emergencies and pre-hospital care needs.

Some of our recommendations: Our full list of recommendations can be found in our written submission. Suffice it to say that Bill 160 needs to go further, to allow a paramedic to be dispatched as part of a fire crew, so that a qualified medical first responder can arrive at the patient's side as quickly as possible. Bill 160 now does not have any communication about that. It just simply talks about the ability for the government to excuse itself, for the purposes of pilot projects—

The Chair (Mr. Grant Crack): Thank you very much. We appreciate it. Sorry to cut you off.

We'll start with the government, and Ms. Vernile.

Ms. Daiene Vernile: Good afternoon, Rob and Mark. Thank you very much for the presentation.

I did very quickly go through the package. It's very encouraging to hear that you are in favour of empowering front-line workers so that they can use their skills and their talents to help patients with their outcomes, and also with cost efficiency.

I went to the very end, to your conclusion. I'm going to ask you to elaborate on where you say you're looking for "clearly defined permissive language to accomplish the goal of improving Ontario's emergency pre-hospital care system." Give us some background on what you mean by that.

Mr. Rob Hyndman: As it currently stands right now, a municipality is prevented from utilizing the firefighter-paramedic, as a result of the Ambulance Act. It specifically talks about "land ambulance service"; it specifically

talks about "service provider." It does not allow for the definition to extend into the fire service. So if a municipality decides that they have the capacity and the existing resources, through a number of EMCA-trained firefighter-paramedics, they are currently prohibited from utilizing that capacity.

Ms. Daiene Vernile: Sometimes there can be a turf war between fire services and paramedics, but we need to get past that, right?

Mr. Rob Hyndman: Absolutely.

The Chair (Mr. Grant Crack): We'll move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in and for your presentation. I've been reading quite a bit on the proposal you've put forth and what the government has put forth.

We've had concerns from AMO regarding the fact that this legislation allows us to do the trials so we can show the effectiveness of a firefighter-paramedic. Their concern is, through arbitration, this would be spread across the province before the trials are done. Can you comment on that?

Mr. Rob Hyndman: From a service delivery perspective, if you look at the jurisprudence as it relates to the interest arbitration, we have clearly defined cases from Ottawa in the 1980s, Thunder Bay in the 1990s and Mississauga in the mid-2000s that clearly define where an arbitrator can go as it relates to service delivery versus the ability for a fire association to negotiate terms and wages.

If you look at the Fire Protection and Prevention Act, the service level is clearly set by the municipality based on their needs and circumstances. We don't believe that would be something that would translate into the interest arbitration arena.

Mr. Jeff Yurek: That's the one question that was raised last week. Thank you.

Mr. Rob Hyndman: You're welcome.

The Chair (Mr. Grant Crack): To the third party: Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming, and thank you for clarifying a few things.

My first question has to do with cost and money. You mentioned that in Manitoba and in Alberta the model already exists. When paramedics on a fire truck are dispatched, is it the municipality that picks up the cost, or is it the Ministry of Health?

Mr. Rob Hyndman: It's a shared cost. I'll look at Manitoba as an example. In Winnipeg, it's a shared cost between the city and the province. Through the efficiencies that have been created there, by utilizing our firefighter-paramedics, they are able to actually cancel approximately 12,000 to 13,000 calls a year coming off the streets in Winnipeg, at a significant cost savings of—the last time I reviewed the material—approximately $8 million to $9 million. In a city of 700,000 people, that's pretty significant.

M^me^ France Gélinas: Wow. In the pilots that you are looking to, would the Ministry of Health be a partner to share the cost, or is this going to be a willing municipality that puts out the money first to make an arrangement later?

Mr. Rob Hyndman: All of our discussions with the government have been that the two pilot sites would be fully funded inclusive of the enhancements to the dispatch systems that need to be done before the project would start.

M^me^ France Gélinas: Right now, having paramedic training is not a requirement to become a firefighter, so isn't there a hit-or-miss—that a city dispatch would assume that there's a paramedic on a fire truck, but on some shifts there is not going to be one?

Mr. Rob Hyndman: From a system design perspective, once the legislation moves forward—if it moves forward—and we get into the system design discussion of what the pilot projects would look like, the municipalities would essentially do their own internal audit to see where their resources are and build their model in terms of what their business case would be to move forward on that. They would have that capacity built into that business case already.

M^me^ France Gélinas: Am I way out of line if I would say—let's say you have a fire hall in a downtown core that generates a lot of the calls where firefighter-paramedics could be useful. For the calls that would go there, you would assume that there would be at least one paramedic on the truck, as opposed to some of the other fire halls, where you would not have the same expectation. Am I going in the right direction?

Mr. Rob Hyndman: Yes. The city administration, the management, would utilize their resources based on what their needs and circumstances are. If they have a city core that requires the usage of the firefighter-paramedic in either a high-acuity or a low-acuity scenario, they would be able to build that model. In other jurisdictions where they may have a need for fire and a need for EMS, they could look at more of a cross-trained role which would help our rural and volunteer communities be able to better deliver on both sides of the equation.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate the two of you coming before committee this afternoon.

1440

MEDEC

The Chair (Mr. Grant Crack): Next we have MEDEC, Canada's medical technology companies. We have the vice-president, Ontario and marketing, Nicole DeKort, with us, as well as the vice-president of federal affairs and health systems, Raj Malik. We welcome the both of you to committee this afternoon and look forward to your presentation. You have up to five minutes. Welcome.

Ms. Nicole DeKort: Great. Thank you very much for having us today. As mentioned, my name is Nicole DeKort. I'm vice-president of Ontario and marketing for MEDEC. With me today is my colleague Raj Malik, who is the vice-president of federal affairs and health systems.

Mr. Raj Malik: MEDEC is a national association representing the medical technology industry in Canada. We represent over 100 medical technology companies that are committed to providing safe and innovative products and solutions that help save the lives of patients by improving the accuracy of diagnoses, enhancing treatment options and helping to provide better medical care.

MEDEC supports Bill 160, and we're highly supportive of the Ontario government's objectives towards greater transparency in health care.

Ms. Nicole DeKort: You have our submission today, which has eight recommendations around Bill 160, but we'd like to focus our short time today on the first five.

We'd like to bring the attention of legislators to the need for transparency over buying groups that undertake the majority of purchases of medical technologies in the province. Key differences exist in the purchasing of medical technologies in contrast to the prescribing of pharmaceuticals. As opposed to pharmaceuticals, which are mainly prescribed by physicians, the purchasing of medical technology is done mainly through regionally based shared services organizations and group purchasing organizations in the province. Currently, these buying groups function in a highly independent and autonomous way from the government itself, yet they are important decision-makers in the health care system. For pharmaceuticals, prescribers such as doctors are the front lines and primary decision-makers of what drugs get used by patients. For medical technologies, buying groups make those decisions.

We believe these groups should be subjected to the same standards of transparency and accountability that is the intent of Bill 160. Currently, there is a lack of government oversight over these organizations, and we've seen those risks as demonstrated by the 2013 diluted chemotherapy drug issue. The standing committee report on diluted chemotherapy drugs noted, "Large amounts of public money are involved in these transactions, all of which are conducted without public oversight."

The government has no real authority to review the finances, implement and suggest best practices, and work in partnership to offer Ontarians assurances that they are operating in a transparent and financially accountable way to taxpayers and patients. Their revenue models are based on rebates and value adds, and there is no oversight over how much of that money, if any, gets returned back to the hospitals. When the rebates and value adds are mandatory requirements of contracts, that creates the perception that companies are expected to purchase the awarding of a contract through providing a financial gain to the decision-making organization.

The Standing Committee on Social Policy also noted in the diluted chemo drug report that the salaries of the executives working in these buying groups should be reported under the Public Sector Salary Disclosure Act. Currently, less than half of those organizations report publicly. The standing committee also noted that they should be subject to audits by the Office of the Auditor General of Ontario.

There is also no third-party mechanism in place right now to ensure that the principles of the government's broader public sector legislated purchasing directives are complied with.

In the same spirit that Bill 160 seeks openness and transparency in financial transactions between industry and health care providers, we believe that the Ontario government should seek the same level of public trust through transparency over the finances of the organizations responsible for contracting and spending millions of dollars of taxpayer money.

You have our five recommendations:

—that the Minister of Health, much like Quebec is doing right now, have oversight over buying groups;

—that rebates and value adds should be optional and not mandatory;

—that buying groups are publicly disclosing their salaries, according to the Public Sector Salary Disclosure Act;

—that they are subject to audits by the Auditor General; and

—that the government set up a third-party dispute resolution mechanism for purchasing groups to enforce the BPS directives. Again, Quebec is doing that right now.

Thank you for taking the time to listen.

The Chair (Mr. Grant Crack): Thank you very much. We'll start with the third party: Madame Gélinas.

M^me^ France Gélinas: Thank you so much. I was on the committee that looked at the diluted chemo drugs, and I am really not happy that none of the transparency recommendations that we put forward have been implemented, with the risk of not learning from our mistakes and not moving forward.

What you want is to add the group purchasing organizations, no matter what they're called, to the list in the schedule to make sure that whatever they receive is reported publicly?

Ms. Nicole DeKort: Yes. There's a bit of complexity here in terms of—there's the one level of what Bill 160 is doing with transparency, which is payment from industry to clinicians and physicians. If you're talking about if there should be transparency around industry taking somebody who runs a shared services organization out for lunch—sure. But there's a whole component of what the buying groups do that wouldn't be captured under this. That would be, for example, rebates and value adds. The purchasing group is contracting a portion of what the hospital spends on whatever they buy, and then it goes back from the company they buy it from to the buying group.

M^me^ France Gélinas: I know exactly how it works.

Ms. Nicole DeKort: That's the piece that's kind of missing in all of this.

M^me^ France Gélinas: Okay. The recommendation from the committee was that those value adds be banned; they're still going on full strength. So what you're saying is that those should also be made—if we're not able to ban them, then make them public.

Ms. Nicole DeKort: We think, at a minimum, they should be optional and not mandatory. They're often asked to be mandatory: A company has to give a rebate or a value add. We think that the government should have transparency over where that money goes after it goes to the buying group.

The government appointed a health care supply chain expert panel recently that came out with a report in April. They did really great work, and we know the government is looking at implementing those recommendations. One of the recommendations under there that we support is just to change the whole business model so that the rebates would go to the hospital, which could then be reinvested in patient care, and the hospital would pay the buying group for the services rendered. That's what we think is a better model.

M^me^ France Gélinas: That was the recommendation from the committee on that, as well, which has not been implemented. Thank you.

The Chair (Mr. Grant Crack): We'll move to the government. Mr. Anderson.

Mr. Granville Anderson: Hi, Nicole. Hi, Raj. Thanks for being here this afternoon. I gather that you support the transparency piece of the bill; you just want it to go a bit further.

Ms. Nicole DeKort: Yes.

Mr. Raj Malik: Yes.

Mr. Granville Anderson: Could you expand on that a little bit more? How far would you like it—I know you want some more implementation of the recommendations that you put forward.

Ms. Nicole DeKort: Right. On the transparency legislation itself, most companies are already doing this in other jurisdictions. Most are global companies. We do want to work very closely with the government—there's a lot in regulation in this bill—on what happens in the specifics in regulation. What we would love to see is some of those recommendations from the diluted chemo drug standing committee report and from the current supply chain expert panel be implemented. That would capture more of the transparency needed around how buying groups operate and who they're accountable to. Right now, they are completely autonomous from the government. They are sort of owned and operated by hospitals, but their exact governance isn't known. None of it is publicly known, so they have no direct accountability to the government. I think most people think they should. It's just a matter of how we go forward with that, which we've given our five recommendations on.

Mr. Granville Anderson: Okay. I don't know if any of my colleagues have any further questions. Thank you.

Ms. Nicole DeKort: Thank you.

The Chair (Mr. Grant Crack): Very good. We'll move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. I too sat in on that chemotherapy mishap committee that discussed the issues, and I was quite appalled by the buying groups that came here and the fact that they would not share any of their secret financial data or how much money they're actually recouping. They're multimillion-dollar corporations. So I'm assuming there's plenty of money that was given by the government for purchasing of medical devices and/or medication for hospitals to use in their public system, and we don't know where this money has gone.

I thank you for being here, and I thank you for raising this issue. I'm glad you did, because I want to make sure that this isn't missed. This is our opportunity to fix that segment of the system. Unfortunately, we have to do it this way because those buying groups don't want to do that. They want to stay secretive, and they want to continue to be arrogant towards the Legislative Assembly by being on their own and not really sharing the data. I'm still really not happy with the way this committee or the social policy committee was treated by those groups that sat in this committee and discussed it.

Hopefully we can find a solution to these amendments in the next week and we can fix this problem.

1450

Ms. Nicole DeKort: Thank you. Yes, we do think it's a great time for the opportunity, because again, we have the recommendations from the flu to chemo drug report. Quebec is taking action on this right now. They have a similar system with shared service, as opposed to Alberta and BC, where the shared service organization is government owned and operated. Quebec is taking measures, and we also have the supply chain expert panel report.

We know from our discussions with the government that this is something they're aware of and would like to move forward on. We just think this would be a great opportunity to do it instead of waiting until perhaps another challenge happens in the system.

Ms. Lisa M. Thompson: Well, we can't wait for another challenge.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Grant Crack): Okay. Well, thank you very much for the two of you coming before committee.

Ms. Nicole DeKort: Great. Thank you for having us.

The Chair (Mr. Grant Crack): Oh, it's our pleasure.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Grant Crack): Next, we have on the agenda, from the College of Physicians and Surgeons of Ontario—is it four or two who are going to come forward? Four? What I shall do is I will let whoever would like introduce all of you and perhaps your positions as well.

The floor is yours. We welcome you. You have up to five minutes. I'll give you a little bit more time with the introduction. How's that?

Dr. Rocco Gerace: Thank you, and thank you very much for the opportunity to allow us to appear before all of you today. We are from the College of Physicians and Surgeons of Ontario. As you may know, we regulate the

medical profession. We have a mandate to do so in the public interest.

My name is Rocco Gerace, and I'm the registrar of the college. Joining me today is Wade Hillier, who directs the quality management division of the college; Louise Verity, who's the director of policy and communications; and Jessica Amey, legal counsel at the college.

We are very supportive and feel Bill 160 is an important piece of legislation for Ontario's patients. We will speak today primarily on schedule 9, which creates a new regulatory system for community health facilities. By way of background, the college is already actively involved in facility regulation. We currently are responsible for inspecting or assessing more than 1,300 independent health facilities or out-of-hospital premises which provide multiple diagnostic and surgical services. We believe that not only will the legislation improve and consolidate oversight for Ontario's out-of-hospital facilities, but more importantly, it will go further to ensure patient safety and take important steps to increase transparency and public reporting.

However, we do recommend a number of amendments to the schedule, amendments that we see as essential to ensuring the effectiveness of the proposed new regulatory framework. Today, I will focus on selected areas of concern, but would urge the members of the committee to review our written submission, which is much more extensive.

The areas that I hope to cover today relate to transparency of inspection results, assessment fees, and accountability of the quality adviser.

Firstly, with respect to inspection reports, we feel strongly that patients have a right to know about inspection results in a clinic they're about to attend. We feel that the act has a number of gaps with respect to the regime of reports, compliance and cessation orders, and that amendments are required to address these gaps. After conducting an assessment, while the inspecting body and licensee will be obligated to post the inspection report, they will not be permitted to post any compliance or cessation orders that flow from the inspection. We seek an amendment that will require an inspection body to post not only the inspection report, but also any orders, and for these orders to remain posted permanently.

We also recommend an amendment to require the licensee to post all orders while they are in effect.

With respect to assessment fees, there is a cost to doing assessments. Currently, clinics that we oversee bear that cost. While the act contains regulation-making authority for the development of fees, there's nothing in the act with respect to enforcement mechanisms when there has been a failure of a licensee to pay the established fee. We have, over the years, had the experience of clinics who have refused to pay the fee, leading to costly litigation. We feel amendments are required to ensure that payments of fees is a condition for the issuance, transfer or renewal of a community facility licence.

Finally, I'll comment about the quality adviser. You will know that the act contemplates the appointment of a quality adviser by the executive officer; however, we feel there will be circumstances where the inspecting body has information about a proposed quality adviser. As a member of that particular college, that might speak to a lack of suitability. We recommend, therefore, that both the inspecting body and the executive officer must approve the appointment of a quality adviser and that that adviser be accountable to both groups. Further, we feel the quality adviser must not only—and I'll quote from the act—advise the licensee "on the quality and standards of services" that are provided in a community health facility. We feel that simply providing advice poses a number of challenges, and we feel that this area of the act should be strengthened to more clearly define quality advisers' responsibilities.

In summary, I will reiterate that the college supports the intent of schedule 9 of Bill 160 and respectfully asks that the committee consider our submission and the drafting recommendations that we have put forward to strengthen the act. In our submission, we've also commented on schedules 1 and 4 but won't speak to those today, and we'll leave time for questions.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate it. We'll start with the government side. Ms. Wong.

Ms. Soo Wong: I thank you for your written submission. I just quickly went through it. I want to go to your comments earlier dealing with the transparency piece in reporting. Now, I know in the proposed legislation there's talk about the database that is being proposed. Do you see merits in merging the database? Because I sense that you're asking that the inspection report should be posted somewhere accessible, so that's more transparency that you're asking for. I want to hear more, because I know you have limited time here. I want to ask you about that database, because what is being proposed here is that there be a publicly accessible database that you're asking for that will be helpful for anybody across the province to access.

In terms of making informed decisions, can you elaborate a little bit further? Because I know there were concerns raised in the past about databases and that kind of stuff.

Dr. Rocco Gerace: Sure. We absolutely support the creation of a database. We currently have a database with respect to our Out-of-Hospital Premises Inspection Program. We do not have one for the independent health facilities; that's a ministry program. We are absolutely supportive of a database that's publicly accessible, but we think it should be expanded, given what's in the legislation. There should be more on it: Patients should have the opportunity to see if there are orders or requirements for that particular facility.

Ms. Soo Wong: The other piece is to increase transparency. Can you elaborate a little bit more on why it is so important, especially to your particular college? Because there are lots of issues out there in the media. I want to hear from your college with respect to transparency.

Dr. Rocco Gerace: Sure. We have been absolutely committed to transparency; in fact, long before the media became interested, we had begun a process at our college with respect to transparency and looking at issues that we felt the public deserved to know about. This has been an iterative process. We think we've led the way in terms of transparency of individual health professionals in the province and look forward to going even further. The facilities' recommendations are simply part of that initiative that we've undertaken.

Ms. Soo Wong: Thank you.

The Chair (Mr. Grant Crack): We'll move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today and for your presentation and your lengthy bit of information that you've supported.

Maybe you can touch upon schedule 9, with regard to the community health facilities, and the fact that CPSO already inspects a large number—thousands of them, I would assume. Maybe just state to the committee—we're hearing that these places aren't safe and perhaps, if there's already an inspection process going to a certain standard, they're already being met. So I just wanted some reassurance to the committee that these facilities outside of hospitals are good, and probably will only be expanded on—their being safe—if CPSO is included in Bill 160 going further.

1500

Dr. Rocco Gerace: Sure. Well, I would contradict that impression. They are absolutely safe. They are inspected on a periodic basis. If concerns are found, the clinic will either stop providing services if the concerns are serious enough or be required to fix any deficiencies that are determined in the assessment. That really is actually safer than exists in a hospital. While hospitals go through accreditation, there is not a requirement to address accreditation recommendations, for example.

I would suggest—and I'll get Wade to comment further—that they are absolutely safe, as safe as we can make them within the current statutory and regulatory framework.

Mr. Wade Hillier: Just quickly, the compliance with our assessment programs and inspection programs is extremely high. We don't have a lot of facilities that are in difficulty, and the process that we have in place is one that requires them to act on the recommendations we make. So even where there are concerns, they're able to be addressed quickly, and we have a very high compliance rate with the current standards and expectations.

Mr. Jeff Yurek: So the key going forward, after this bill is passed, is to ensure that CPSO has a main function of ongoing oversight of these facilities, and to ensure that the advisory officer and also the EA are intricately woven into the CPSO and working as a partner.

Dr. Rocco Gerace: Well, assuming that we continue as an inspecting body—and the legislation is silent on that point—we think it's absolutely important that the quality adviser be integrated between the executive officer and the college, and that there be coordinated oversight of these facilities to ensure patient safety.

Mr. Jeff Yurek: I would certainly hope you would be included as an inspecting body after passage of Bill 160.

Dr. Rocco Gerace: We anticipate that that will be the case.

Mr. Jeff Yurek: Otherwise, I think it would be back at the Legislature in the next six months to 12 months to fix the situation. Thank you.

The Chair (Mr. Grant Crack): We shall move to the third party, the NDP. Madame Gélinas.

M^me^ France Gélinas: Just so that I fully understand, you want included that the inspection results and the orders be posted, and the orders would stay on your website forever and be available. Would we also see what was done to comply with the orders?

Mr. Wade Hillier: Yes. It's anticipated that the inspection report and a summary of the report would also be on the website, so our ability to report out on what's been addressed would be anticipated.

M^me^ France Gélinas: Okay. So in the bill—by memory—they say two years or two inspection cycles; you say to leave it there forever.

Mr. Wade Hillier: We have taken the position that it's important for patients to know what the history is, and we've talked about it as two inspection reports, because obviously we don't inspect every year. We might be inspecting on a three-year or a four-year cycle in certain facilities, so we would only see one report. So at a minimum, it should be at least two reports.

M^me^ France Gélinas: Okay. And the licensee would also have to post orders while they're in effect? Do any of them do this now?

Mr. Wade Hillier: Right now, if there is a condition on the licence as imposed by the ministry through the Independent Health Facilities Program, they're supposed to. There is no such requirement in the out-of-hospital program. The posting, of course, is difficult because we have no inspection to ensure that the posting is happening. Right now, we have two different processes for what happens on the ministry website related to the independent health program and what happens on our site. But there are no orders currently. We don't have orders in place in the current program. All we have is the outcome of an inspection. There is no orders power currently.

M^me^ France Gélinas: True. And failure to pay the fees where you have to go to litigation: Can you give me an example of where this actually happened?

Dr. Rocco Gerace: I can. We had one particular facility that simply refused to pay for the inspection. In order to collect that fee, we had to go to Small Claims Court. We were successful, but that involved multiple processes and litigation because that facility, in turn, appealed the decision of the Small Claims Court. We think that's simply a waste of resources. If you have a member of the profession—a doctor can't practise unless they pay their fees clearly set out; we think the same should apply to facilities.

M^me^ France Gélinas: Could you give me an idea of the range of the fees that a—

Mr. Wade Hillier: Currently, it will depend on the type of service. If it is a complicated surgical-type procedure, we might be sending out three assessors at once, for example: a proceduralist, an anaesthetist and a nurse. If it were a simple procedure, we might be sending out one assessor. So the ranges can be quite varied, but we did build a model based on our extended experience within the Independent Health Facilities Program. So it can range from as small as about $500 for an inspection that's related to an eye procedure that we're required to look at under the ministry, or it could be up to $4,000 or $5,000, depending on the type of procedure.

M^me^ France Gélinas: Do you know if—

The Chair (Mr. Grant Crack): Thank you very much. We'd like to thank the four of you for coming before committee this afternoon. We appreciate your input. Thank you.

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

The Chair (Mr. Grant Crack): Next, we have the Nurse Practitioners' Association of Ontario. We have the interim chief executive officer with us, Dawn Tymianski, I believe.

Ms. Dawn Tymianski: Almost.

The Chair (Mr. Grant Crack): Tymianski.

Ms. Dawn Tymianski: Yes.

The Chair (Mr. Grant Crack): There we have it. Thank you kindly for coming before committee this afternoon. We welcome you, and you have up to five minutes for your presentation.

Ms. Dawn Tymianski: Okay. Thank you so much. My name is Dawn Tymianski. I'm pleased to introduce myself as the new interim CEO of the NPAO. I'm a proud member and a former board member of the NPAO and a practising adult nurse practitioner.

NPAO is the one and only NP-led professional association in Ontario that has the voice of over 3,100 nurse practitioners.

We are pleased today to have the opportunity to comment on and speak to members of the standing committee about Bill 160, Strengthening Quality and Accountability for Patients Act, 2017.

NPAO in general supports the intent and purpose of Bill 160 to strengthen access, quality of care for patients, accountability and transparency in the health care system. NPAO is pleased to provide its key recommendations related to four schedules in the bill. As part of our submission, comments and recommendations related to other schedules will also be provided.

Schedule 1, the Ambulance Act: NPAO supports amendments to the Ambulance Act that will provide paramedics with the ability to transport patients to non-hospital settings based on patient care needs. This is an important change as it will help reduce unnecessary visits to emergency room departments for non-acute patients. NPAO recommends that the patient's choice should always be sought when considering ER diversion options.

NPAO has concerns about the implications of section 7.0.1(3)(b)(iii), which states, "An operational or policy directive by the minister that may ... include, but is not limited to ... the adoption of treatment models" of care "for persons with lower acuity conditions."

This proposal creates patient safety concerns if paramedics are providing care outside of their competencies and without adequate supervision, and may also contribute to fragmentation within the primary care system. As a result, NPAO does not support this proposal as it currently reads. NPAO does agree that paramedics may, with additional training to enhance skills and competencies, be able to provide limited on-the-scene, non-acute care to patients as a short-term measure to reduce visits. However, that on-scene care cannot and should not be a substitute for the patient's primary care provider. Should the act, as proposed, be passed, a referral from the paramedic to the patient's primary care provider must be mandatory to ensure appropriate diagnosis, continuity of care and follow-up. NPAO is also interested in participating in any discussions regarding standards and models of this care.

Schedule 4, Health Sector Payment Transparency Act: NPAO strongly supports the proposed new legislation for the disclosure of financial relationships between heath care providers and manufacturers of medical products. It is well documented that payments made to health care providers can influence decision-making. For example, a health care provider may choose one medical product over another because of the financial incentive provided by that manufacturer. Increased transparency as proposed by the bill should help to sustain and enhance trust of patients in their health care provider and health care system.

NPAO also recommends and supports the proposed approach to set out details within regulations regarding recipients of transfer-of-value types of payments and values of thresholds. NPAO welcomes the opportunity to provide feedback.

NPAO also recommends that the context and background for information that is made publicly available concerning transfer of values be included in the posting to not only increase patient understanding but also to help prevent the legislation from becoming punitive for the provider.

Schedule 7, Ontario Drug Benefit Act: NPAO supports the proposed amendments to the Ontario Drug Benefit Act. These additional amendments will expand the list of prescribers by permitting NPs to prescribe from the limited-use formulary. These changes are an extension of the changes that were made earlier this year through the Patients First Act. NPAO has long advocated for the changes that enabled reimbursement for drugs prescribed by NPs for their patients from the ODB formulary through the Exceptional Access Program. Changes as set out in schedule 7 are critical to increasing patient access to medications in a timely manner by nurse practitioner prescribers.

1510

NPAO is also the sole professional association working with the Ministry of Health and Long-Term Care to

facilitate NP designation for eligible NPs under the palliative care facilitated access program. The PCFA NP designation will enable nurse practitioners to prescribe medications without delay to help alleviate pain and suffering for their palliative care and end-of-life patients. This access for eligible qualified NPs is anticipated in the near future.

Schedule 9, Oversight of Health Facilities and Devices Act: NPAO supports the establishment of a single framework to govern energy applying and detecting medical devices, including X-rays, CTs, MRIs, ultrasounds, nuclear and molecular imaging devices. NPAO believes this approach will enhance protection for patients. NPAO recommends that the authority of who is authorized to order and perform procedures and treatments using EADMDs be set out in the new act. This authority does not appear to be set out in the current legislation.

Since 2009 and the passage of Bill 179, nurse practitioners have waited patiently for the proclamation of the Healing Arts Radiation Protection Act and for changes to enable NPs to order CTs, MRIs, forms of energy such as defibrillation, and to perform point-of-care testing. The proclamation of HARPA is now set for April 2018—nine years after the changes were first made, but not enacted to permit NPs to order all X-rays. NPAO strongly recommends that the repeal of section 6 of HARPA as proposed be delayed until this new NP X-ray authority comes into effect. Without this authority, NPs will need to continue to rely on physicians and medical directives to order these tests, resulting in delays in patient access, diagnosis and treatments for their patients.

The Chair (Mr. Grant Crack): Thank you very much. We'll start with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: I noticed in your written document, with regard to HARPA, that you're still unable to order X-rays.

Ms. Dawn Tymianski: Yes. This is nine years after Bill 179 was passed. So we have patients who have significant delay in diagnosis or treatment or management.

Mr. Jeff Yurek: As we try to expand access to nurse practitioners, they're still having difficulty—

Ms. Dawn Tymianski: Absolute barriers to care—especially in the community, within the acute-care system. We have medical directors within that system, but in our northern communities nurse practitioners still have to rely on a physician to order an X-ray of a pelvis with a patient complaining of a fractured hip or something like that. They still can't order them independently nine years after it was supposed to be passed.

Mr. Jeff Yurek: It seems we're filling in the scope of practice for nurse practitioners piecemeal instead of just taking care of it all at once. We know where we want to take you. Why can't we just do it?

Ms. Dawn Tymianski: Absolutely. We are one of the last provinces in the country to be able to do that independently, which is of interest because Ontario, by far, has the largest number of nurse practitioners in the country. We significantly bypass the statistic numbers for the country.

Mr. Jeff Yurek: And we were one of the earlier provinces with nurse practitioners?

Ms. Dawn Tymianski: We were. Some provinces only have 10 or 15 nurse practitioners; we have 3,100. And we still can't order X-rays when we're working independently in our nurse-practitioner-led clinics. So it's very much a big barrier to practise.

Mr. Jeff Yurek: Is there anything else you'd like to add with regard to concerns from NPAO?

Ms. Dawn Tymianski: Now that MAID has come into effect, there is a formulary where they've created a list of physicians and nurse practitioners who can order end-of-life or stronger than usual for narcotics and pain-relieving medications that are above and beyond what a normal patient would require, and nurse practitioners are somewhat still excluded from that list. A nurse practitioner or a physician managing patients requiring certain analgesics for pain management—we can't order the same medications that we're legally able to because we still don't have a list for that.

Mr. Jeff Yurek: Thanks for coming. We'll be leaning more on nurse practitioners as our health care system continues to evolve and grow.

Ms. Dawn Tymianski: I hope so. That would be fantastic for us.

The Chair (Mr. Grant Crack): We'll move to the NDP. Madame Gélinas.

M^me^ France Gélinas: It's a pleasure to see you again.

Ms. Dawn Tymianski: Thank you for asking us to come.

M^me^ France Gélinas: My first one is, when we talk about the Health Sector Payment Transparency Act, schedule 4 of the bill, you said that you strongly support it. Would you agree that the value of samples left behind would be considered a transfer of value?

Ms. Dawn Tymianski: Yes, it would.

M^me^ France Gélinas: It would? Okay. Would you agree to set the minimum at $10, so that anything over $10 gets reported?

Ms. Dawn Tymianski: Yes.

M^me^ France Gélinas: You would? Okay. Other organizations that have come forward have suggested that not only would they be health care providers and manufacturers of medical products, but also if they provide electronic health records. If they are not providing care, if they are not providing drugs or medical products, but they are providing elements that are used within a health care setting, would you agree to capture those?

Ms. Dawn Tymianski: Yes, I would agree to capture those.

M^me^ France Gélinas: Cast a wide net?

Ms. Dawn Tymianski: Yes.

M^me^ France Gélinas: Any idea why it is so slow to get nurse practitioners to work to their full scope? Have you identified a barrier, or is it a moving target?

Ms. Dawn Tymianski: I think it's a moving target, but we're still somewhat of a new kid on the block. We recognize the need for care in Ontario, for an alternative provider that can work to full scope of practice. People

who have nurse practitioners who take care of them are extremely satisfied. Research suggests that nurse practitioners are an efficacious way to provide care.

Certainly, bringing more nurse practitioners forward, providing nurse-practitioner-led clinics to meet the needs of Ontarians—right now, we service about six million Ontarians with nurse practitioner care, which is quite significant. But there's a long way to go in terms of the care that we can provide, and getting more nurse-practitioner-led clinics out there.

M^me^ France Gélinas: I'm jumping to schedule 7, which has to do with the Retirement Homes Act. Under the Retirement Homes Act, we will now be allowing restraint and confinement in retirement homes, which have no oversight by the government whatsoever except for common law, where you protect somebody for minutes or hours. Does the NPAO support using restraint and confinement in a retirement home?

Ms. Dawn Tymianski: Absolutely. People have an opportunity to live where they want. "Restraint and confinement" really needs to talk about minimal restraint, but it has to be judicious in the fact that we have to also provide safety for patients—our clients—and caregivers and the community, and understanding that the SDM, the substitute decision-maker, understands that it is in the patient's best interest to do so.

M^me^ France Gélinas: Okay.

Ms. Dawn Tymianski: Thank you so much.

The Chair (Mr. Grant Crack): Okay, thank you very much. I appreciate it.

We'll move to the government. Ms. Wong?

Ms. Soo Wong: Thank you for being here again.

Ms. Dawn Tymianski: Thank you.

Ms. Soo Wong: I remember seeing you guys last week when you were here for the NP day. I remember that last week, yes.

Ms. Dawn Tymianski: The Queen's Park day, yes. That was fantastic.

Ms. Soo Wong: I read your written submission. Generally, you are supportive of this particular proposed legislation. I know that in your presentation this afternoon, you referenced the concern over section 6 of the HARP act piece. I can tell you that the government—if the legislation is passed, there will be consultation with respect to it. I anticipate that the NPAO will be invited to participate in that consultation, because we are concerned about patient safety.

Ms. Dawn Tymianski: Absolutely.

Ms. Soo Wong: I just want to push the envelope a bit further with respect to you recommending not to repeal that particular section until that piece gets done. Can you give more comments about that particular piece? I know there's a movement that wants to do it faster—like yesterday—and others that say, "Let's have a good, robust consultation, and have a good talk about this whole piece," because there are implications for the system.

Ms. Dawn Tymianski: Absolutely. I think that providing patient safety through this act is what's required.

If we use MRIs for an example, and NPs ordering MRIs, there are some very strong guidelines on which patients can have MRIs and which patients cannot. We would fall under that same information. Our knowledge, skill and judgment would pertain to that. I think that, when you look at the rationale for having NPs being able to do this, it really is to provide timely, efficacious, complete therapeutic care for patients, so I think that opening that up and providing for the NPs to do what is required to be done for patient care, we really need to be very thoughtful in moving that forward.

1520

Ms. Soo Wong: Thank you very much for all your hard work and to your association.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate your coming before committee this afternoon.

Ms. Dawn Tymianski: Thank you so much.

The Chair (Mr. Grant Crack): You're welcome. Have a great afternoon.

ADVANTAGE ONTARIO

The Chair (Mr. Grant Crack): Next we have AdvantAge Ontario. We have the board chair, Jane Joris, and the interim chief executive officer, Mr. Robert Morton, with us this afternoon. We welcome the two of you to committee and we welcome your presentation, up to five minutes. The floor is yours.

Ms. Jane Joris: Great. Thank you very much for having us this afternoon. I am Jane Joris, the chair of the board for AdvantAge Ontario. With me today is Robert Morton, our interim CEO.

AdvantAge Ontario is a voluntary membership organization. Our association represents not-for-profit seniors' care providers. Members include municipal and not-for-profit long-term-care homes, seniors' housing and community services. Our submission and our comments today deal specifically with schedule 5 of Bill 160. My remarks will be focused on two areas: recommended amendments to schedule 5, and additional measures that are needed to enable homes to meet care and compliance standards that support improved resident outcomes.

Our recommendations for amendments are as follows. First, the amendments to section 69 must not proceed. They remove the due diligence standard and replace it with an unreasonable standard that requires every officer and director to ensure compliance. The amendments also create a draconian measure that would mean corporate prosecution or conviction would not be necessary for a director or officer to be prosecuted and convicted.

We further recommend that, like their hospital counterparts, long-term-care boards exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances and take such measures as the board of the corporation considers necessary to ensure that the corporation complies with all requirements under this act.

Second, we recommend amending Bill 160 to support a deferred proclamation of 12 months and/or to identify a 12-month transition period to provide homes with the necessary time to implement the new requirements.

Our third recommendation is that the Long-Term Care Homes Act be amended in order to give district homes more flexibility in their financing and to raise mortgages on their own faith and credit so they can proceed with their redevelopments as mandated by the ministry. While this recommendation is not specific to schedule 5 of the bill, it addresses a significant issue. We are aware this committee has received this recommendation from the five district homes, and our association fully supports it.

We know that we will not be able to ensure that residents receive the highest quality of care simply by legislating requirements and strengthening the ministry's enforcement options. We strongly believe that there are key additional measures that must accompany schedule 5 of Bill 160.

Our three measures are as follows. First, staffing investments are required immediately to ensure residents receive the level of care they need and deserve. This priority is echoed by all stakeholders in the sector. The complexity and level of care that residents require is higher than ever before. Research evidence clearly shows that more staff will mean better quality of care, better resident outcomes and greater resident safety.

While we appreciate and welcome the government's recent commitment in Aging with Confidence: Ontario's Action Plan for Seniors to increase the provincial average to four hours of direct care per resident per day, we are urging that the work begin now to make that a reality. Adequate care for Ontario's seniors is not a partisan issue.

Our second recommended measure calls for greater flexibility to support homes that are challenged in their efforts to recruit and retain staff. The legislative and regulatory provisions currently in place specify staffing levels and qualifications that are extremely difficult for many homes to achieve, particularly in rural areas. As a result, homes are found non-compliant for things that are completely outside of their control. We support the need for qualified and trained staff, but homes must be given room for creative and innovative solutions to staffing challenges. We put forward in our paper a number of examples where we believe added regulatory flexibility and/or expansion of exceptions could support homes in their recruitment and retention efforts without compromising the care and safety of residents.

Our third recommendation calls for a coaching-for-compliance program. A wealth of knowledge and data has been gathered by the ministry in the seven years that the inspection and compliance program has been operational. It's time for this intelligence—the best practices, analysis, trends and other valuable information—to be strategically shared with the sector so we can work together to help all homes achieve compliance with the act. This recommendation was put forward five years ago by the Long-Term Care Task Force on Resident Care and Safety. The Auditor General's 2015 report also urged a similar action.

Schedule 5 in Bill 160 is an important step toward the implementation of a legislated rights-based framework for confinement and addressing significant issues of compliance risk. However, without the amendments and additional measures that we have recommended to you today, homes will struggle to achieve compliance success, particularly in areas related to resident care.

We urge the government to move forward on our recommendations. We believe they will have an immediate and positive impact on the quality of care and quality of life of long-term-care residents. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate that. We'll start with the government. Ms. Wong.

Ms. Soo Wong: Thank you very much for your presentation and your written submission. It's quite lengthy, which is good.

I'm just going through your written submission here. Can you elaborate a little bit further? Because of all of the health sectors, I would say that the long-term-care sector has the most challenges in terms of retention and high transience—you know, that kind of population. What do we need to do better? I come from that sector; I've taught in that sector. What do we do better?

You highlighted rural areas. I would say even here in an urban centre it's a big issue. So can you give us some examples? On page 5 of your written submission, you're asking for more creative, innovative solutions. Can you share some of those creative, innovative solutions with us that are evidence-based?

Ms. Jane Joris: Yes. On page 6, we have some recommendations: being able to use developmental service workers in PSW positions; being able to hire PSWs who are enrolled in the course but not yet graduated, and for us to be able to provide the practicum.

We also need—it was nice that we followed the nurse practitioners today—to look at the scope of the RN and RPN so that we can make sure we're in compliance with the requirements for registered staff. The 24/7 RN obligation in the act is difficult for a number of homes, particularly in the north, to be able to meet that compliance.

Ms. Soo Wong: I want to hear a little bit more about, at the bottom of page 5, the coaching for compliance. Can you share with us a little bit more about that particular initiative?

Ms. Jane Joris: Sure. So before the new compliance program was in place, we would have an inspector come to our homes, and she or he would say to us, "You're having some challenges in wound care. If you talk to this other home, they have a great program. Here's the best practice. Here's what we've learned from our analysis." We don't get that anymore. We get, "You're not meeting the act."

We think that the ministry has a lot of information and data that they've gathered over the seven years, and we'd like them to share that with this sector so that we can be successful in meeting compliance.

Mr. Robert Morton: Let me add to that as well. You may know that Health Quality Ontario recently hosted Health Quality Transformation, a gathering of 3,000 quality improvement specialists from across the health care field and the largest quality gathering in Canada. One of the keynote speakers was Dr. Don Berwick from the Institute for Healthcare Improvement, and he clearly made the point that you do not improve quality in a health care setting—long-term care, community care or hospital care—by adding controls. You achieve quality by working with all of the practitioners to get focused on the person they're serving and create innovations that will result in quality.

This quality versus control balance is one that, with respect, I suggest we're out of whack in in Ontario. The compliance program, the inspection program, is not meant to help us improve; it's meant to shame and blame operators who are failing to meet the standards. It's not related to clinical outcomes and the care that people are receiving.

1530

The Chair (Mr. Grant Crack): Thank you very much. We appreciate it.

We'll move over to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here today. I just wanted to touch on the coaching for compliance. The government asked what they can be doing. I think this is a pretty straightforward suggestion that it seems the industry has been waiting for. The fact that they have data they've been collecting for five years—how long is it?

Ms. Jane Joris: Seven years.

Mr. Jeff Yurek: Seven years. There has been a call, for the last five years, to share this data to help the industry.

I know that the industry in general, in the view of the public, probably has a black eye right now, with the inquiry that's going on. I think this type of information can be quite vital to ensuring that the public has confidence in the long-term-care sector in the province.

I'm just shocked that we're still waiting, five years and an Auditor General's report later, to see some action. You're hopeful that it's happening this next year, or that's your wish?

Ms. Jane Joris: That's our wish.

Mr. Robert Morton: We have recently submitted additional proposals to the government, to the Ministry of Health and Long-Term Care, with respect to moving forward on a coaching-for-compliance model that includes enhanced education supports, better reporting back on quality initiatives, and better sharing of best practices.

Mr. Jeff Yurek: Has the ministry given you any indication of why this isn't happening, why they aren't sharing the data with you? Is there a glitch in their systems? Do you know?

Mr. Robert Morton: I'm not going to speak on behalf of the ministry. It's a complex issue. There are lots of homes, and there's lots of data. Just as we heard in previous presentations this afternoon, transparency of data related to inspection reports—that includes the effectiveness of the reports. We need to not only be looking at the performance of long-term-care facilities; we also need to be ensuring that we have good inter-rater reliability, that the inspectors who are doing the work are doing so in a way that meets the broader needs of the residents of the homes.

Mr. Jeff Yurek: Health Quality Ontario could take that data and come up with some direction for you. They're utilizing them for other standards and such.

Mr. Robert Morton: Going back to Health Quality Transformation, I was really proud that when Dr. Tepper talked about the significant improvements within the system over the last year, since his last report and Measuring Up, the real gains have occurred on the long-term-care side: reduction in use of restraints, reduction in falls, reduction in the use of psychotropic drugs—some very good outcomes for long-term care.

Mr. Jeff Yurek: Great. I appreciate it. Thank you.

The Chair (Mr. Grant Crack): We'll move to the third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: Thank you very much, Ms. Joris and Mr. Morton, for attending today. We know there's a lot of work that can be done in long-term care. You had talked, in one of your suggestions, about the draconian fees, the penalties, that may be faced by long-term care. I wanted to ask you how you felt that financial penalty achieves better patient outcomes in long-term care.

Ms. Jane Joris: I don't think that the financial penalty will achieve better outcomes. I think money is already very tight. Previously, if there was a fine, it came from the nursing and personal care envelope. With this bill, it can come from any envelope, which will make a difference if people do have to pay fines.

I think that coaching for compliance is a better way for us to achieve compliance than fines and penalties.

Ms. Teresa J. Armstrong: Would you say, then, that those things maybe don't help patient outcomes, if that's something that's proposed in this bill?

Ms. Jane Joris: I don't think that we've seen any evidence that those fines or penalties do improve patient outcomes.

Ms. Teresa J. Armstrong: Can you talk about the confinement piece that's in here, with regard to long-term care—how you're going to manage that, how you're going to comply with it and how it maybe affects your residents that you have in long-term care?

Ms. Jane Joris: I think we'll have to see the regulations. Currently, as you know, we rely on the common-law duty if we believe that someone is at serious risk for bodily harm. I think with the new bill, it will mean that people will have access to a rights review person, but how that will work and how we'll be able to manage that and fund that, I'm not sure at this point. We always want to make sure that we try everything else before we confine someone.

Ms. Teresa J. Armstrong: One last question: You talked about the data and sharing data. How do you see

the process of that data being shared, so that it can help patient outcomes and compliance?

Ms. Jane Joris: I think that there are a number of levels where that can be shared: first of all, in annual reports about best practice, what's working, how other homes can implement the processes and programs that are working. Even when the inspectors come to the home, if they identify something, they might be able to give us some idea about how we could do that better, or if there is someone they could put us in contact with who's doing that better. Perhaps there are resources that could be used for coaches to go to homes that are having difficulty with compliance.

M^me^ France Gélinas: How worried are you about section 69? If it proceeds forward, do you think that you will have a hard time recruiting board members and executive members to your homes?

Ms. Jane Joris: Yes, we do.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate the two of you coming before committee this afternoon.

Ms. Jane Joris: Thank you.

Mr. Robert Morton: Thank you.

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

The Chair (Mr. Grant Crack): Next we have on the agenda the Ontario Council of Hospital Unions/CUPE. We have the president, Michael Hurley, and researcher, Doug Allan, with us this afternoon. We welcome the two of you to committee, and you have up to five minutes for your presentation.

Mr. Michael Hurley: Thanks so much for having us. We really appreciate the opportunity. We have a brief for you, and the brief covers the changes as they affect long-term care, retirement homes, public and private hospitals and also paramedic services. But we wanted to focus our remarks on hospitals, retirement homes and long-term care, if that's okay.

First of all, it wouldn't be an overstatement to suggest that private clinics in Ontario have a very troubled history, and approximately 98% of the independent health facilities in Ontario are operated on a for-profit basis.

We are quite concerned about the legislative changes in this bill. First of all, there is no restriction on for-profit clinics and for-profit hospitals. That's a pretty dramatic departure, as we have this aggressive downsizing of the hospital sector, which is protected under the Canada Health Act. There's a good question about what happens to these services as they migrate to the community and whether they continue to enjoy the protection; that is to say, whether they are operated on a universal not-for-profit basis or whether they are in fact subject to operation as a for-profit entity. We're quite concerned about that.

The act removes a key existing protection for privatization in the repeal of the Private Hospitals Act, which was meant to fence in the six private hospitals in the province of Ontario.

There is little substantive change in this bill and there is little substantive change that provides protection to patients or their families. This bill does not address the potential for extra billing of people who use these clinics.

With respect to the Long-Term Care Homes Act, this legislation will impose new requirements on long-term-care homes without necessarily providing an increase in staff. We are very concerned with respect to changes around retirement homes, which have been hitherto pretty much universally unregulated, operated on a for-profit basis, staffed on a skeleton basis, and which are now picking up more and more work as it gravitates from the hospitals. These facilities were never intended to be anything more than places where people went to retire, like an alternative to an apartment. They weren't meant to be convalescent facilities. They weren't meant to be mental health facilities. They are not staffed on that basis. They are some sort of a discount health care operation, and they exist entirely in the for-profit sector.

1540

We flag those concerns for you. We go through them elaborately in our brief about the bill, and we would be happy to attempt to answer any questions you might have.

The Chair (Mr. Grant Crack): We move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today. This is quite a document. I noticed on schedule 1 you have mentioned the firefighter-paramedic. Could you talk about that? We've had quite a different discussion through the last few days with regard to that. We have the professional firefighter association here today, so I was wondering if you could touch on CUPE's stance on that.

Mr. Michael Hurley: Sure. Actually, Mr. Allan is way more conversant on that issue than I am.

Mr. Doug Allan: Sure. We did make a deputation through our sister organization, CUPE Ontario, on that earlier. But to highlight: This act does, through section 22(1)(f), allow essentially cabinet to exempt the application of the act, which is an extraordinarily broad power, very troubling, and could open up a whole number of areas.

Key among those—one among many potential disasters—would be the introduction of firefighter-paramedics done without any of the extensive regulation that exists right now through the Ambulance Act and its regulations. In fact, we've attached a 34-page appendix, Appendix B, which sets out hundreds and hundreds of requirements for oversight and regulation of this very vital service.

The idea that they could proceed on firefighter-paramedics or private patient transfers without this sort of regulation in legislation is appalling, in our view. We're extremely troubled by that and we have a lot of other arguments that are in there about why it's inappropriate to have a second-class EMS system rather than just

building the appropriate EMS system. It's gone over in our brief in some detail.

Mr. Jeff Yurek: Your second point in your conclusions, "to allow diversion of ambulances from hospitals only in certain circumstances": Have you laid out which circumstances that would be?

Mr. Doug Allan: Yes, and in fact we've made specific proposals which are attached, I think, in Appendix C, where, for example, we list fully public facilities which we think may be appropriate in certain circumstances—low-acuity cases only. Hospitals are the appropriate destination for the vast majority of 911 calls because they have the range of facilities. Ambulances are not diagnostic vehicles. That is not what they're designed for and not what they can do. That is not appropriate for them, and you don't actually know what is troubling you until you have a comprehensive diagnostic at a treatment facility such as a hospital. There may be some cases, and we are not standing in the way of that, but we had to make specific recommendations in Appendix C.

Mr. Jeff Yurek: So you're ensuring patient safety is the key to the—

Mr. Doug Allan: Utmost, and I'm not clear that this is done in this act as it's written now.

Mr. Jeff Yurek: Just a question in general: Are we utilizing paramedics to their full scope of practice in our health care system today?

Mr. Doug Allan: Full scope of practice?

Mr. Jeff Yurek: Could they do more?

Mr. Doug Allan: Paramedics right now are second only to doctors in terms of the scope of services that they can provide. They are delegated, they are not a college-regulated profession, but it's very broad. When you have an emergency and somebody is dying, the scope and what the base hospital physician will allow you to do is up to the base hospital physician. It's not exactly an issue in this bill, but there is an extremely broad scope for paramedics as is extremely necessary, and the idea of proceeding on that basis with fire trucks is just mind-blowing.

The Chair (Mr. Grant Crack): We move to the third party. Madame Gélinas.

M^me^ France Gélinas: I would say that I agree with you that medicare means that we can go to a hospital, we can visit a physician and we don't have to pay. Care is based on need, not on ability to pay. The minute you take a hospital service and put it into the community, well, the Auditor General told us that 98% of the time it means that we send it to the for-profit sector. There is nothing in this bill that will change this trend—much to the opposite, where you see that with the removal of the Private Hospitals Act, then we're opening up the door to more and more.

One of the things that irks me to no end is that we will now call those private clinics "community health facilities." Could you comment on this, and see that from the Oxford dictionary, a community is sharing in common; it means public spirit. Can you see any of this in the for-profit clinic opening?

Mr. Michael Hurley: It's interesting to us that hospitals aren't perceived to be community health organizations, but that for-profit entities could be. We're quite aware, as you are, of the meta analysis that was done in the Canadian Medical Association Journal of death rates in private and public hospitals and death rates in public and private dialysis facilities. I'd point you to the dialysis finding, which was that the death rates were higher in the for-profit dialysis centres, because the authors found there was a skimping on staffing and blood cleaning products.

What we're talking about here is life-and-death stuff. This is whether you have a system motivated by altruism and compassion or whether it's driven by another motive, which causes cost cutting and staff cutting and results in much worse patient outcomes; that is, higher morbidity, higher mortality. So, yes, we're very concerned about that, Ms. Gélinas.

M^me^ France Gélinas: The government is saying that they will bring strengthened oversight to the private clinics, but none of it is in the bill; we have to trust that it will be in regulation. I can't do this, because I have been led to think that regulations would be coming that never came, and when they came, they were not what they said. Do you have any suggestions for us that we would put in the bill as to what the oversight should look like?

Mr. Michael Hurley: We've got a very troubled history of lack of oversight of these clinics, and a delegation of oversight to bodies which are perhaps in a conflict of interest, like the College of Physicians and Surgeons of Ontario overseeing operations which are owned by doctors who are members of the College of Physicians and Surgeons of Ontario.

That's an excellent question. Do you have thoughts about that?

Mr. Doug Allan: Well, we have seen—

The Chair (Mr. Grant Crack): Quickly, please; we're out of time.

Mr. Doug Allan: Okay. We have seen a significant increase in physician incomes through alternate funding mechanisms, and that has been driven by lobbying by doctors, so we do think there is a bit of conflict there, between a doctor-driven organization overseeing this. We think it's properly done in the public sector, and we need much more detail on how they must report. There's a whole long series of problems of poor reporting by the CPSO. It has been taken up by the Toronto Star—very troubling. None of that is covered by the bill.

Mr. Michael Hurley: So there would either have to be direct oversight, or you shouldn't move the services, right? There has to be a direct, transparent, legitimate oversight, or the thing is a fraud.

The Chair (Mr. Grant Crack): We'll move to the government side. Ms. Wong.

Ms. Soo Wong: Thank you very much for your presentation, Mr. Hurley, and thank you, Mr. Allan, for being here.

I'm just going to go back to your comment in your oral presentation about the Retirement Homes Regulatory

Authority. My understanding is that when we're making amendments to the proposed legislation there will be more power by the RHRA in terms of inspection in terms of the unlicensed homes, because there are lots of unlicensed homes—I come from the Toronto area—and making sure they are compliant. I want to hear your comments about that, because we've got to strengthen that authority so that they can shut down those unregulated homes. Do you have any concerns or questions about the strengthening of that authority?

Mr. Michael Hurley: These for-profit organizations were never designed to provide health care services; that was never their purpose. We wouldn't see them as legitimate vehicles for the delivery of health care services. They're not staffed for that; they're not regulated by that. Providing them with better regulation is not the answer, in our view. Operating these services, for example, in long-term-care facilities which are licensed would be where we would see that that should happen, or retaining some of these beds and services in the hospitals where they're also properly regulated, where they're accredited, where they're subject to inspection, where they're subject to the revocation of accreditation, and where the whole thing is not driven by some other motive, which is financial.

The Chair (Mr. Grant Crack): Mr. Anderson.

1550

Mr. Granville Anderson: Thank you for being here and thank you for your presentation. My daughter, as a matter of fact, is a member of CUPE. She's a paramedic.

I just wanted to make it abundantly clear that this government is committed to publicly funded health care. We have six private hospitals. You alluded to the fact that there isn't enough oversight. The only way we could provide that oversight is to open that up and to look at it so that we can provide that oversight. The intent is not to expand on private health care; it's to make sure that those oversights are in place for those six hospitals there. I know the third party—I'm not sure why they fearmonger, because that's what they do. This is not the intent of that; it's to make sure that oversight is provided for those hospitals that are already private hospitals.

You alluded to the fact that there wasn't enough oversight and the outcomes were not what they should be versus the publicly funded hospitals. Could you expound on that?

Mr. Michael Hurley: Yes.

Mr. Granville Anderson: I just wanted to make sure those concerns are—

Mr. Michael Hurley: Yes. We don't see oversight. We see services being moved from facilities which are covered by the Canada Health Act, where there's an understanding that they're delivered on a not-for-profit, universally accessible basis, free of charge, into the for-profit sector, where there already have been problems with user fees and extra billing for these services, where the regulation has been a shambles, to the detriment of the consumer, frankly. The whole project puts in jeopardy, ultimately, the universality of the health care system because it's a steady movement of these services into a for-profit environment, which is unregulated, largely. The regulation that we've seen to date has been, frankly, almost nonexistent, conflictual in interest. We've been misled, I think, as a public, in terms of it being rigorous when it never was. I don't share your confidence today, honestly.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate the two of you coming before committee this afternoon.

TRUDELL MEDICAL INTERNATIONAL

The Chair (Mr. Grant Crack): Next on the agenda we have Trudell Medical. We have the chief executive officer, Mr. Gerald Slemko, and the external affairs manager, Sean Marshall, with us this afternoon. We welcome the two of you to committee. You have up to five minutes for your presentation.

Mr. Sean Marshall: Good afternoon. I'm Sean Marshall. I'm the external affairs manager with Trudell Medical International. Thank you very much for the time that we have this afternoon.

We're here to just talk really briefly about valved holding chambers, specifically the AeroChamber, which many of you are familiar with. Just to give some context, valved holding chambers are a very important delivery device for people who need to have inhaled medications. What's important is that a valved holding chamber delivers the dose of medication that is supposed to be delivered by an MDI.

On that note, I'm just going to hand it over to Gerald Slemko, the CEO for Trudell Medical.

Mr. Gerald Slemko: Good afternoon. Thank you very much for allowing us to attend and present today.

Trudell Medical is a London, Ontario, company that works with patients, caregivers, health care providers and patient associations like the Ontario Lung Association and Asthma Canada to help patients to breathe better and to live fuller lives. Our focus is all around asthma and COPD.

Just to give a background on Trudell, it's a Canadian family-owned and operated company. It manufactures and distributes globally—around the world—medical devices and provides respiratory services throughout Ontario. It's been operating since 1923, and today we employ about a thousand employees globally and 590 employees in Ontario alone. Our head office is actually located in London, Ontario, which is the riding for MPP Deb Matthews.

Trudell was the pioneer in developing and marketing the valved holding chamber device, including the AeroChamber. We currently sell that product in about 110 countries around the world. We are the global leader in that product category and we're proud that our devices are actually manufactured here in Ontario.

We support all of our development programs with significant and impeccable clinical research. Our focus is patient care, and we validate all of our products. All of

our research is done with an impeccable amount of clinical research and focus on delivering patients the best value. We strive to reduce the burden that respiratory challenges bring to patients and their caregivers, and are committed to bringing the best innovative lung health products and services to those who struggle to breathe.

We were pleased to see the efforts that the government has undertaken to present before the Legislature such a comprehensive piece of legislation focused on health care. We join our lung health partners in highlighting the need for this government to address lung disease, and specifically the difficulty that we and our health care partners face in listing valved holding chambers, which are sometimes referred to as spacers, for the management of asthma.

The use of valved holding chambers is required for young toddlers and infants to properly inhale their medication. The AeroChamber is an effective and simple chamber to use, and has been shown to reduce the number of asthma attacks in children.

Asthma alone affects millions of people, including 13% of Canadian children. That's one out of every five children here in Ontario. Unfortunately, in Ontario, chambers continue to remain out of the hands of those who are most vulnerable and who can't afford one.

It's very clear that with good asthma management, including the use of a chamber, an asthma sufferer can usually enjoy a symptom-free, full and active life. The science is unmistakeable. Metered-dose inhalers, which are sometimes referred to as puffers, combined with chambers, provide those who suffer with asthma the proper dose of medication to help them manage their disease.

Hospitals have replaced nebulizers with chambers as a standard of care in the emergency department. However, there is no path for reimbursement for chambers in Ontario, as it does not meet the ODP or the assistive-devices requirement. Across Canada, other provinces including Alberta, Manitoba, Saskatchewan, Quebec, Nova Scotia and Newfoundland routinely reimburse chambers, yet under Ontario's many health assistance programs and supports for those most vulnerable, chambers are simply not covered or accessible, even though the data and the science outlining the benefits are clear.

According to a joint statement from the Canadian Paediatric Society and the Canadian Thoracic Society on diagnosis and management of asthma in preschoolers, inhaled corticosteroids "are to be administered by metered-dose inhaler with an age-appropriate valved spacer" or chamber.

While Bill 160 may not deal directly with helping Ontarians access medically necessary devices such as valved holding chambers, it's our hope that you will look for ways within the scope of Bill 160 to list chambers under one of Ontario's many medical assistance programs, perhaps, most fittingly, under the government's OHIP+ program. Similar to other provinces that cover AeroChamber devices, offering patients 24 years of age or younger drug-free care and the medically necessary device that delivers that drug to where it is most needed, the lungs, will greatly improve the lives of these patients.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate that. We will start with the third party. Ms. Gélinas.

M^me^ France Gélinas: Thank you so much for coming today. I appreciate it. Can you give me a sense as to, of the people who use Ventolin or any other puffers, as I will call them, what percentage could benefit from using it through one of your products, one of those chambers?

Mr. Gerald Slemko: Well, clearly everyone benefits in some respects. Certainly children and seniors, who have more difficulty coordinating the actuation of the puffer and the inhalation, benefit the most, but it does benefit across the whole range of anybody who is using an inhaler.

M^me^ France Gélinas: As a first step, if Ontario is moving forward with OHIP+, that will cover, as you mentioned, people under 25 years of age. Would it be appropriate, then, that those chambers be covered for that population as a start?

Mr. Gerald Slemko: Yes, that would be very appropriate.

M^me^ France Gélinas: And right now, what are the mechanisms—how much does one of those cost, anyway?

Mr. Sean Marshall: At a pharmacy, it's regularly about $35, or $55 for a mask. This would be a mask, and then this would be a mouthpiece, which would be about $35.

1600

M^me^ France Gélinas: About $35. But I could see that if you have a young family, $35, or even for a child, for a mask, a $50 expense—do you know for a fact that there are some children who would benefit from having this device who, right now, cannot afford them?

Mr. Sean Marshall: That's a very good question. Our reps are in regular contact with all the specialists across Ontario and GPs, and they regularly give us feedback that there are many children who go home after a family doctor visit without having been able to fill the prescription that's given to them.

M^me^ France Gélinas: I don't know if you're able to do this, but could you give us a scope as to, if Ontario was to cover this for children and for people over 65, but let's start with children, how much you figure as an expense for the Ministry of Health that would represent? Any idea?

Mr. Sean Marshall: It would be a relatively low cost because valved holding chambers are—it's a limited amount of the population. So, as we mentioned, around about 13% of the population is diagnosed, so it's difficult to really pinpoint an exact amount, but it wouldn't be significant compared to many drugs.

M^me^ France Gélinas: How long do they last? If you get one of those masks, do you need a new one every month or do you keep using the same one?

Mr. Sean Marshall: Generally, it's expected that a valved holding chamber would be replaced annually, so once a year.

The Chair (Mr. Grant Crack): Thank you very much. We'll move to the government. Ms. Vernile.

Ms. Daiene Vernile: Welcome, gentlemen. Very interesting to listen to your presentation. I have a son who just turned 30, and I can tell you that as a child and as an adolescent we had to deal with asthma, and I lost track of the number of times we would have to go into the hospital when he was having difficulty breathing. In particular, I remember on those bad air days, the smog days that we used to experience in Ontario—I believe in 2005 it was a record number, that year. It was about 55. But since we closed down 19 coal-burning plants in Ontario, the number of bad air days we have had in the province has been zero.

I'm sorry. I should get back to the reason why you're here, but I'm very proud of that fact and it's meant a lot in my family.

Can I ask how long your company has been in the city of London?

Mr. Gerald Slemko: Since 1923.

Ms. Daiene Vernile: How many employees do you have?

Mr. Gerald Slemko: We have 590 employees in the province of Ontario. We have about 1,000 employees globally but 590 in the province of Ontario, and approximately 350 of those are in London.

Ms. Daiene Vernile: And did you mention to how many countries you ship your product?

Mr. Gerald Slemko: Yes, to about 110 countries around the world.

Ms. Daiene Vernile: Since I was buying puffers back in the late 1990s, the early 2000s to now, have there been many technological advances?

Mr. Gerald Slemko: Yes. We spend a lot of time on research and we've developed a lot of technology. We were the originator of the valved holding chamber. It was actually developed out of McMaster University in Hamilton—the concept—and Trudell took that concept and developed it and was a world leader in terms of developing it. It's a product that undergoes continual development and continual process. We have a significant engineering research department. We have a significant clinical development department that works on continuing to look at applications and making the device more effective and, as medications change, ensuring that medications are effectively delivered. So, yes.

Ms. Daiene Vernile: We thank you very much for being here. Did you want to add something?

Mr. Sean Marshall: I was just going to say, I think something that we take a great deal of pride in is that we have one of the most advanced aerosol labs in the world, that many manufacturers recognize, and we actually validate some of the equipment that is developed in overseas markets.

Ms. Daiene Vernile: Okay. Thank you for being here and for your information. We'll take what you've said into account.

The Chair (Mr. Grant Crack): Thank you very much. We'll move to the official opposition. Ms. Thompson.

Ms. Lisa M. Thompson: Very good. I just have a comment before I pass it along to my colleague Jeff Yurek. I want you to know that my father lived or learned to live with COPD and he used your chamber for years, and I witnessed the benefit of it. I'm glad you're here.

The Chair (Mr. Grant Crack): Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here. It's important that you've brought this information forward. I see the aerochambers as equally important in the treatment of asthmatics and those with COPD as I see insulin pen needles and insulin needles—the same need for diabetics to get access to. Unfortunately, Ontario diabetics and asthmatics are limited to their access unless they have a drug plan.

I think it's vitally important that you discussed OHIP+. We have children and youth now who can access the AeroChamber via their private plans that will most likely cut back on what they're covering because OHIP+ has come forward. Hopefully, you're making progress outside of the Legislature with regard to getting this product covered. I think it's vitally important. Hopefully we can find some room in this.

I just want to touch Bill 71, the Lung Health Act. I would like to have that amended and added to the legislation. Do you have thoughts on that bill, considering it's a tri-partisan bill?

Mr. Sean Marshall: Yes, I think that makes a lot of sense.

Mr. Jeff Yurek: Great, I appreciate that. Hopefully, if this doesn't get added in this bill coverage, know that we're willing to work with you—the PC caucus—in ensuring that this product gets covered for all Ontarians, not just OHIP+. I think even seniors need the benefit of an addition with COPD, etc. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We thank the two of you, gentlemen, for coming before committee this afternoon. It's much appreciated.

COLLEGE OF PHYSIOTHERAPISTS OF ONTARIO

The Chair (Mr. Grant Crack): Next on the agenda, from the College of Physiotherapists of Ontario, we have the registrar and chief executive officer, Shenda Tanchak, and the president, Gary Rehan. Welcome, both of you, to committee this afternoon. You have up to five minutes for your presentation. The floor is yours.

Mr. Gary Rehan: Thank you very much, Mr. Chair. Members of the committee, thank you very much for the opportunity to address to you today. My name is Gary Rehan. I'm a practising physiotherapist. I live in Athens, Ontario, with my wife, Richa, who is also a physiotherapist and operates a few physiotherapy clinics in our community. I'm the president of the council of the College of Physiotherapists of Ontario. I'm today joined by the registrar and the CEO of the College of Physiotherapists of Ontario, Shenda Tanchak.

As you know, the college of physiotherapists is not an educational institution. We are one of the 26 regulatory

health colleges in Ontario. We are the bodies that license physiotherapists and investigate complaints and concerns about them. This role gives us a unique lens on the health care system.

A few years ago, we began to see a concerning trend. When we discussed it with our regulatory colleagues, they had seen it too. So 18 of us got together to better understand the problem and brainstorm solutions. Today I speak on behalf of this group of colleges about a gap in patient protection that we believe could be addressed by the Oversight of Health Facilities and Devices Act that is proposed in Bill 160.

As you know, most of the clinics where health care is delivered in Ontario are under absolutely no regulation. Many of these clinics are owned by business people who are not health professionals and have no duty to protect patients. These unregulated employers dictate practices or care models that conflict with our members' professional obligations.

Whether it is unacceptable infection control practices associated with acupuncture, the use of a vast stable of unsupervised, unregulated assistants, or fraudulent billing practices, when these concerns come before the college, our only recourse is with the employee. We can see the real risk of harm, but because the college does not have jurisdiction over the employers and the workplaces, we are unable to stop dangerous or wasteful practices.

The group of colleges I represent believes that despite the effective regulation of health care professionals, there is an accountability gap which puts patients and the health care system at risk, and is a barrier to providing patient-centred care. The working group believes that the gap exists because clinics and their unregulated owners owe no formal duty of care to patients and have no formal obligation to meet standards. We believe that this gap in oversight can cause harm to patients and the health care system as a whole. Patients suffer as a result of unsafe practices and inadequate treatment.

There is also economic harm on many levels. Wasted health care resource spending on activity that is not genuine care, lost productivity when patients cannot return to work and unnecessary visits to doctors and hospitals: These would be additional unnecessary burdens on an already strained health care system.

We believe that some form of clinic oversight would be in the public interest, and ask the Ministry of Health and Long-Term Care for the opportunity to work together to identify an appropriate solution. We understand that the types of clinics that we are talking about are not contemplated to be included in the regulations under the proposed act. We understand this is because they are not considered to be a high-enough risk. In the clinics that I'm talking about, there is a risk of physical harm, not necessarily the sort that makes headlines.

We urge the government to look beyond catastrophic physical crisis events and to understand risk and harm. It has done so before. When the extent of insurance fraud in motor vehicle accidents cases was recognized, the government created an oversight mechanism through the Financial Services Commission of Ontario because it recognized that extensive economic harm was also a risk for the Ontario public. We believe that Bill 160, specifically the proposed Oversight of Health Facilities and Devices Act, offers an opportunity to address the accountability gap that we have identified.

We applaud the government for including a definition of "community health facility" that is sufficiently broad to allow flexibility to extend the oversight and public protection benefits to many different types of health care settings and services. We urge the government to consider including non-medical clinics and health care practices into the community health facility oversight regime.

I speak to you on behalf of the College of Physiotherapists of Ontario as well as the colleges for audiologists and speech and language pathologists, chiropodists, dental hygienists, dental technologists, kinesiologists, massage therapists, occupational therapists and opticians. Thank you very much for the opportunity to speak today.

The Chair (Mr. Grant Crack): Thank you very much. It's much appreciated. We'll start with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here today. So you're asking the Ministry of Health to create a regulatory body for these clinics? I'm just following your discussion.

Ms. Shenda Tanchak: No, rather to ensure inclusion of these clinics in the health facilities that are already in Bill 160.

Mr. Jeff Yurek: So the clinics that aren't owned by regulatory health professionals: You want them brought in to ensure that it's standard across the board. Is that—

Mr. Gary Rehan: Yes.

Mr. Jeff Yurek: Okay. I get that; it makes sense. What you're saying is that with those that are regulated health professionals, their colleges are taking care of that health professional. However, the ones that aren't regulated health professionals are left out, and you need to fill in that gap, then. The colleges currently in place cannot expand to take in those facilities. Is that what you're saying?

Interjection.

Mr. Jeff Yurek: Okay. Have you spoken with ministry officials about this and have you had a response from them?

Ms. Shenda Tanchak: Yes, we have discussed it with them. They have recognized the need, and we understand that it's not impossible, that at some future date these clinics could be included, but it's not contemplated in the short term.

Mr. Jeff Yurek: So we're going to create a piece of legislation where the public is not really going to know which ones have proper oversight regulations and which ones do not until we get around to it?

Ms. Shenda Tanchak: I think there is a potential for risk of confusion.

Mr. Jeff Yurek: So if we fix this in some form of an amendment to the legislation, then it would have to be dealt with sooner than later.

Ms. Shenda Tanchak: I think that's right.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Grant Crack): To the NDP: Madame Gélinas.

M^me^ France Gélinas: Thank you for coming. I just want to be sure of your answer. Right now the college, you regulate the members, you oversee your members for the protection of the public. But if the member owns a clinic, does that give you the right to oversee the clinic—their billing, their practice—or solely the practice of physiotherapy?

Ms. Shenda Tanchak: So long as a regulated health professional is the clinic owner, a college is likely to be able to protect the public, one way or another. However, many, many of these clinics are owned by laypersons who aren't registered anywhere. Those are the ones we are most concerned about.

M^me^ France Gélinas: I just wanted to make it clear.

When you do your duty to protect the public from harm coming from poor care—everybody gets this, but would you also look at financial harm to patients? Is this within the scope of your college to look at that?

Ms. Shenda Tanchak: Yes, we do now. We have standards with respect to billing practices as well as a code of ethics. It's very common. In fact, it's one of the goals in our college's strategic plan to ensure ethical billing practices.

M^me^ France Gélinas: How can the public know that a clinic has been overseen by a college and is doing fine, and the one next door is not?

Ms. Shenda Tanchak: Because we presently have jurisdiction only over the individuals, the way we can clean up the practices at a clinic are by ensuring that the individual running it is abiding by the standards or ethical requirements or regulations or bylaws. We actually don't have jurisdiction over the clinic, so we kind of sneak in through the back door. We couldn't say that the clinic itself hasn't passed any test even today.

M^me^ France Gélinas: So the public is left to nothing at all—absolutely nothing.

Ms. Shenda Tanchak: That's right.

M^me^ France Gélinas: This is not good news at all. That needs to change. I thank you for bringing this forward.

You see Bill 160 as an opportunity to expand what they call community health facilities to include community-based clinics not only run by physicians, but by all of the colleges that you just mentioned: massotherapy, physiotherapy, kinesiology—I forgot the whole list. We know that all of those different colleges support this because it will be written in here someplace?

Ms. Shenda Tanchak: The list of colleges that are part of our group is in the submission that we provided to you. You shouldn't understand that to mean that the others would not also be supportive of the idea. It was the group that came together to do the research and the extensive public consultations, but that didn't mean the others were opposed to it.

The Chair (Mr. Grant Crack): We shall move to the government. Ms. Vernile.

Ms. Daiene Vernile: May I just get some clarity on what you're presenting? The clinics that you want to have regulated are not the ones on page 2? These are the ones who are part of your working group?

Mr. Gary Rehan: Yes.

Ms. Daiene Vernile: Talk to us about the clinics that you have described as dangerous and wasteful. Who are they?

Ms. Shenda Tanchak: They are clinics where members of our colleges work. Sometimes they're wellness clinics where lots of different regulated health professionals work alongside a lot of people who aren't regulated and the clinic is owned by an entrepreneur. One way to approach it would be to define "community health facility" as any place a regulated health professional works. If you think that the regulated health professionals are those who are empowered under the legislation to undertake both the most helpful and the most dangerous activities—there are places where they work that don't support the meeting of their professional obligations. So it's a range of places.

Ms. Daiene Vernile: When you say "dangerous," can you describe that to us? Give us some examples.

Mr. Gary Rehan: An example would be reusing acupuncture needles, which could be a decision made by the owner if the organization and the regulated health professional decides to do that. Our recourse is only towards the regulated health professional because that's where our jurisdiction ends; it's not towards the business owner.

Ms. Daiene Vernile: What would oversight look like to you?

Ms. Shenda Tanchak: I think that the model set out in the legislation works just as well for community health facilities under our kind of idea of what that includes as it does for those that are medically led today. It looks like regular inspections to ensure a level of quality is attained and then recourse if a problem is identified.

Ms. Daiene Vernile: My colleague wants to ask a question.

The Chair (Mr. Grant Crack): Ms. Wong.

Ms. Soo Wong: How many unregulated clinics are we talking about?

Mr. Gary Rehan: In terms of the regulated health professionals that our group represents, we're talking about more than 70,000 regulated health professionals who are members of the colleges that I was mentioning. In terms of the clinics, there are no clear numbers because we did not collect statistics about those clinics, because we don't regulate clinics. We regulate physiotherapists or we regulate regulated health professionals. But it could be estimated that these clinics are in the thousands.

Ms. Soo Wong: There were recent charges laid against some of those physiotherapist clinics. Are they the ones that are unregulated owners of those clinics?

Ms. Shenda Tanchak: In fact, no physiotherapists work at those clinics. That's a very good example. It's an unregulated clinic owned by an individual—not a

regulated health professional at all—who used the word "physiotherapy" in the advertising.

The Chair (Mr. Grant Crack): We'd like to thank the two of you for coming before committee this afternoon. We appreciate your input.

Mr. Gary Rehan: Thank you very much.

ONTARIO ASSOCIATION OF MEDICAL RADIATION SCIENCES

The Chair (Mr. Grant Crack): Next, from the Ontario Association of Medical Radiation Sciences, we have the chief executive officer, Mr. Greg Toffner, with us. We welcome you, sir. You have up to five minutes for your presentation, followed by nine minutes of questioning. The floor is yours.

Mr. Greg Toffner: Thank you very much for having me here today. I'd like to thank the committee for having me come and speak. I represent the Ontario Association of Medical Radiation Sciences. We represent the medical radiation sciences practitioners across the province of Ontario in the disciplines of radiological technologists, radiation therapists, nuclear medicine, MRI and diagnostic sonographers.

1620

As the association representing the medical radiation sciences profession, we have been working with the Ontario government to modernize the dated radiation safety legislation and to regulate sonographers on behalf of our members. We are very excited and pleased with the progression and contents of the bill in the interests of public protection and in the advancement of quality health services.

On behalf of Ontario MRTs and sonographers, I'd like to thank Minister Hoskins and his staff; ADM Patrick Dicerni, Sean Court and their staff; ADM Denise Cole and her staff; and in particular MPP John Fraser, for all their work and perseverance on these files.

The legislative and regulatory changes required to modernize the existing Healing Arts Radiation Protection Act and to regulate sonographers is very complex. It has required careful thought, consideration and levels of consultation to get to where we are today. It definitely was not easy, and there's still a lot of work to be done.

The current legislation, the Healing Arts Radiation Protection Act, affects 90% of the work that our members do every day, but there are more than a dozen other professions that it will affect to varying degrees. It also crosses over a number of other pieces of legislation, so it becomes very convoluted and difficult. It's never easy to try to keep all parties happy and to navigate through the rough waters to achieve a meaningful solution. We know the environment because it affects 90% of everything that our members do on a regular basis and the patients we serve. We've been very pleased to be working with the current government in that regard over the years.

Today, other than saying that we're really happy about those two areas of the bill—the HARP Act modernization moving forward, as well as the regulation of diagnostic medical sonographers under the College of Medical Radiation Technologists of Ontario—I think it's very important that these changes continue to progress in a meaningful and timely manner in the interest of public protection. Obviously, we're assuring that Ontarians will continue to receive world-class services. That will continue into the future under a very sustainable structure. I think the way things are moving and the way things are setting up, we're headed in the right direction.

The Chair (Mr. Grant Crack): Thank you very much for your presentation.

We'll start with the third party, the NDP. Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming. I don't know how much you follow the legislative process, but there was a group before you representing the nurse practitioners, and they were here nine years ago telling us that they needed to go in that direction, and we agreed to go in that direction but we did not put it in legislation. Fast-forward nine years: They are no further ahead than they were before on those points they came to see us about today.

So when I hear you say, "We are going in the right direction, but we are not there yet," I urge you to be very specific as to what it is you want your end goal to be, because nine years from now, you may be back in that seat saying, "We all agreed. We knew where we wanted to go. But it never got done." The more you wait for stuff to be put in regulation, the more the risk that it will never happen. If there is something that you want to happen, say it, put it in the bill and it's done. Otherwise, I cannot guarantee you that it will ever happen.

From what you've shared with us today, you want the sonographers to be regulated and you want the oversight to be there. Are there any other pieces that you want done and put in the bill? Otherwise, you're at risk that nine years from now, you will be like the nurse practitioners, coming back to see us and saying, "You said you were going to do this. You changed a lot to be able to do this but never did it."

Mr. Greg Toffner: I can't overstate how complicated the process is and was. I know many of you around the table. I visited you throughout many lobby days and I am confident with the legislation that is going through. That is what is going to enable us to write the regulations that are required to modernize the current piece of legislation and all of the issues that we're currently having. It was based on a piece of dated legislation that goes back to the early 1980s.

In that regard, yes, I think we're comfortable with where it's heading at this stage. As for the regulation of sonographers, that's a really important piece that we've been involved in working closely with the government, and we're happy with the amendments that were put forward in both the MRT act and the Regulated Health Professions Act and the regulations that are going to be moving forward.

M^me^ France Gélinas: Okay. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We move to the government. Mr. Rinaldi.

Mr. Lou Rinaldi: Thank you for being here today. Stating how this legislation impacts the people that you're representing, I think it's important that we all hear it. It's a bit different from my colleague who just asked questions before me on not having any beliefs in regulation. I think, to the best of my understanding—I'm not an expert—the legislation would create a framework that, once we get moving, once that's done, then through a set of consultations—I think your group has been consulted, same as others that have been here today. I'm not sure I've heard of a group that hasn't been consulted as building this up, and there will be amendments. To build something now—until we know what the end goal is, I don't think it's fair for government and I don't think it's fair for the other partners.

My question to you is on the framework legislation that we're talking about today, Bill 160, and the modernization that we're going through: How does this technology impact your sector specifically? Do you see any benefits in the direction that we're going in?

Mr. Greg Toffner: Yes, I see a number of benefits. Obviously in our business there is a lot of technology. It's a moving target, and having a dated piece of legislation where you had very pointed details—the actual legislation was very prohibitive to moving anything forward and building anything that was progressive that will sort of evolve with the times and allow the flexibility, as technology and practice change, to move that forward in an effective manner.

I think what we're seeing here in terms of building our framework is that it's going to be very effective in that we're building a piece of legislation that is broadened with modern times—and the idea that you build the specific details under the regulations that are a little more nimble and flexible and easier to change on an as-needed basis, based on the practice trends and technology.

Mr. Lou Rinaldi: From a non-expert on the issue, but certainly being open-minded, your particular industry, in the whole health sector umbrella—it's one of them that's probably like my iPhone. When I bought it, the next day they came out with a new version. I'm sure it's in the same sense.

I mean, I have the privilege of representing three hospitals in my riding. A few years back, when one of them had the opportunity to be awarded—and they did get it—an MRI, I remember speaking with a radiologist about eight months later, and they wanted to raise more money for an upgrade. I was really kind of shocked. It wasn't even a year. I went, "Is there a shortfall with that new machine that you have?" And he said, "Oh, absolutely not; it was the best that we could get at that time." So I certainly appreciate your comments. Thank you so much.

Mr. Greg Toffner: Thank you.

The Chair (Mr. Grant Crack): We move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you for coming in today. I'm reiterating what the third party has mentioned: Now is the time to let committee know if there are any concerns at all, because once it goes to regulations, we're out of the picture—for us to make these changes to go forward, just for the record.

Technology changes so quickly nowadays, we have no idea what we're going to be doing 10 years from now. Does this bill have enough flexibility in it? Are there any other problems that we need to deal with? We'll be able to handle these new technological advances that we're going to see in the next little while, in your opinion?

1630

Mr. Greg Toffner: Yes, in my opinion, I believe it does. In fact, it's much more broadened to include non-ionizing forms of radiation as well, as an example. I think it opens the door for us to do more under regulations because of it. I think it's being built so that we have that flexibility. It will help us to make sure there's a sustainable structure moving into the future.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Grant Crack): I'd like to thank you for coming before committee this afternoon. It's much appreciated.

Mr. Greg Toffner: Thank you very much.

The Chair (Mr. Grant Crack): Have a good afternoon.

COLLEGE OF MEDICAL RADIATION TECHNOLOGISTS OF ONTARIO

The Chair (Mr. Grant Crack): Next, we have the College of Medical Radiation Technologists of Ontario. We have the registrar and chief executive officer, who has waited patiently right from the start, Linda Gough, and then Debbie Tarshis, who is counsel.

We welcome you to committee this afternoon. You have up to five minutes for your presentation.

Ms. Linda Gough: Great. Thank you very much. My name is Linda Gough, and I'm the registrar and CEO of the College of Medical Radiation Technologists of Ontario, or CMRTO. We have our external legal counsel, Debbie Tarshis, from WeirFoulds, with me today.

We're pleased to be here this afternoon, and thank you for the opportunity to make our submission. We're going to be speaking specifically to Bill 160, schedule 6, the Medical Radiation and Imaging Technology Act. We believe that this is an important piece of legislation to ensure the protection of the public of Ontario.

CMRTO is the regulatory body for medical radiation technologists in Ontario. Our mandate is to regulate the profession, to serve and protect the public interest. We are one of the 26 profession regulatory colleges governed by the Regulated Health Professions Act. We regulate 7,000 registered medical radiation technologists in four specialities: radiography, nuclear medicine, magnetic resonance and radiation therapy.

The legislative framework proposed by schedule 6 expands the specialties of medical radiation technology governed by the CMRTO to include diagnostic medical sonographers. This will provide a single, integrated legislative framework for all medical radiation and imaging technologists under one regulatory college.

Diagnostic medical sonographers are those health care practitioners who use high-frequency sound waves to produce images of the body, to assist in the diagnosis of disease, disorders or dysfunctions. For example, they perform ultrasounds on pregnant women to assist in the monitoring of fetal development and to screen out problems. They also do cardiac ultrasounds to assist in the evaluation of heart conditions or suspected heart problems. Diagnostic ultrasound has become an essential tool in the medical imaging and diagnostic techniques used in health care today.

The regulation of diagnostic medical sonographers with CMRTO means that we will develop, establish and maintain qualifications for sonographers to become members of the college. We will require applicants to meet specific entry-to-practice requirements; we will have standards of practice applicable to all five specialities, including sonographers; and we will be requiring sonographers to be accountable for their practice through our complaints, discipline and fitness-to-practise procedures.

The public interest will be protected, as the CMRTO will ensure that sonographers are qualified to practise and are practising professionally. The public will have access to the CMRTO's robust complaints and discipline processes.

In addition, transparency will be improved, as members of the public will be able to identify those persons who are qualified to practise in the specialty of sonography and those who are not, under our public register, which is available on our website.

Schedule 6 proposes to repeal the Medical Radiation Technology Act and replace it with the Medical Radiation and Imaging Technology Act. The new act will govern the practice of medical radiation and imaging technology under one regulatory college. The CMRTO will become the College of Medical Radiation and Imaging Technologists of Ontario and will govern the profession in accordance with the RHPA and the new act.

We're very pleased that the new act introduces a new name, the College of Medical Radiation and Imaging Technologists of Ontario. Most members of the public and, in fact, diagnostic medical sonographers themselves don't identify sonographers as medical radiation technologists because sonographers apply sound waves to create diagnostic images, not radiation. This is an important piece for us. This name change improves transparency and understanding for the public. It also reflects the common terminology used in the clinical settings. In hospitals and clinics across the province, medical imaging departments include the specialty areas of radiography, nuclear medicine, magnetic resonance and diagnostic medical sonography all in the one area.

We commend the government's proposal to express the scope of practice for the practice of the profession in a transparent manner under the new act. The scope of practice is updated by adding sound waves as a form of energy to the current energies of ionizing radiation and electromagnetism. The updated scope of practice will be the use of ionizing radiation, electromagnetism, sound waves and other prescribed forms of energy for the purposes of diagnostic or therapeutic procedures, the evaluation of images and data relating to the procedures, and the assessment of an individual before, during and after the procedures. This updated scope of practice is comprehensive. It's an integrated statement which describes the practice of all five specialties.

We support the provisions set out in the new act regarding title protection, which restricts the title "diagnostic medical sonographer" to members of the college. Each RHPA college has a specific title or titles restricted to its members. The purpose of title protection is to ensure that no person can use the title without being registered with the appropriate college. In the context of regulating a new specialty, we're especially pleased that "diagnostic medical sonographer" is a protected title. This serves to protect the public, as it will prohibit untrained and unregulated persons from calling themselves diagnostic medical sonographers—

The Chair (Mr. Grant Crack): Thank you very much. I'm sorry to interrupt. I gave you an extra minute, so I kind of broke the rules a bit. However, we'll start with the government. Mr. Anderson.

Mr. Granville Anderson: Did you want to finish anything?

Ms. Linda Gough: All I wanted to say is that our written submission has some technical amendments that we need to make sure are changed so that the legislation achieves its intended—

Mr. Granville Anderson: Thank you for being here. The previous presenter also mentioned sonographers as well. You would see these unregulated sonographers as a gap or an oversight in the bill? You wanted that corrected. Do you know why sonographers were not a part of your college to begin with?

Ms. Linda Gough: It's one of those technology evolutions that we've been talking about. Many individuals, including other health care professionals, believe that sonographers are already regulated. Our counsel believes that it's in the public interest to regulate sonographers with CMRTO because the practice is essentially the same; it just uses another form of energy. The entry-to-practice requirements are very similar too. There's an accredited educational program. There are certification exams. It has evolved to be very similar to MRTs.

Mr. Granville Anderson: So we have recognized that and sonographers are being regulated in the bill.

Ms. Linda Gough: Correct. We've also received direction from the assistant deputy minister, Denise Cole. In August we received a letter directing us to regulate sonographers with CMRTO by January 2018. These changes in the legislation support the regulatory initiative that has already started.

Mr. Granville Anderson: Overall, I gather you are supportive of the bill?

Ms. Linda Gough: We are, yes.

Mr. Granville Anderson: Okay. Thank you very much.

The Chair (Mr. Grant Crack): Thank you. I'll move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here and for your deputation today. Can you talk a bit about the titles and the correction you want to see with regard to "nuclear medicine technologist" from "therapist"?

Ms. Linda Gough: Yes. That's an error. It's "nuclear medicine technologist." "Nuclear medicine therapist" is incorrect. We have radiation therapists and nuclear medicine technologists.

Mr. Jeff Yurek: So that was just a blip in the writing of it?

Ms. Linda Gough: Correct.

Mr. Jeff Yurek: And if it's not fixed and changed, we run into causing a lot of problems in the health care system?

Ms. Linda Gough: We do, yes.

Mr. Jeff Yurek: Okay, great. We'll take a look at that. Thank you.

The Chair (Mr. Grant Crack): Madame Gélinas.

1640

M^me^ France Gélinas: Thank you so much. So you want "specialty" to be redefined in the bill. You want some medical radiation technologists and medical imaging technologists to be added, and "nuclear medicine therapists" to be changed to "nuclear medicine technologists." You want bylaws to be changed to simply regulation, and then, the last one, a new subsection 14(3.1): "The bylaws made under the Medical Radiation Technology Act, 1991 that were in force on the day before section 15 of this act came into force become the bylaws made under this act." What does that mean?

Ms. Linda Gough: Correct. What's happening with the legislation is the College of Medical Radiation Technologists of Ontario becomes the College of Medical Radiation and Imagining Technologists of Ontario. So we have a new name. This will take time for us to go through all our bylaws and policies to make sure that everything is working in conjunction for the date the legislation and the regulations come into force. It's really a legislative tool to enable us to make sure that we can phase in all these regulatory and bylaw instruments that we need to make sure are in place.

M^me^ France Gélinas: I think it's clearer.

My last question is that I know of some clinics that use people who are not your members to do the work. Is there anything in the bill that would ensure that everybody who does that work is actually your member, or will it continue to be allowed under—I forget what it's called. A physician can delegate under a delegated act.

Ms. Linda Gough: The holding-out provision would help resolve that issue, and that's an important provision that's in the legislation that we would like to see enacted.

M^me^ France Gélinas: Sorry?

Ms. Linda Gough: It would require anyone who is practising the profession, holding themselves out as a member and also practising in a specialty of the college, to be a member of the college—that they wouldn't be able to hold themselves out.

M^me^ France Gélinas: I get it about the title; they wouldn't be allowed to hold themselves out, but they are still allowed to do the work under delegations from a specialist or a physician. Yes?

Ms. Debbie Tarshis: Under the RHPA model, really any act that is a controlled act authorized to be performed by a health profession can be delegated by the health profession that's authorized to do it. However, the big change that is anticipated to go along with this is that there's a controlled-acts regulation, and the change that is anticipated is that it will require, in order for a person to apply sound waves for diagnostic purposes, that they be a member of this college. That's a regulatory change as opposed to in legislation.

M^me^ France Gélinas: Okay, so I don't see this in the bill because it will be in regulations when the regulations will come out.

The Chair (Mr. Grant Crack): Thank you very much. I appreciate the two of you coming before committee this afternoon. Thanks for your insight.

ONTARIO NURSES' ASSOCIATION

The Chair (Mr. Grant Crack): Next we have, from the Ontario Nurses' Association, the first vice-president, Vicki McKenna, senior director Bev Mathers and government relations officer Lawrence Walter. We welcome the three of you to committee this afternoon. I don't think it's the first time that some of you have been before committee. The faces are familiar. We welcome you. You have up to five minutes for your presentation.

Ms. Vicki McKenna: Thank you. My name is Vicki McKenna. I'm a registered nurse and a provincial vice-president with the Ontario nurses. With me, as you've introduced, are Lawrence Walter, government relations officer, and Bev Mathers, senior director at ONA.

I'm a practising registered nurse and practised in London Health Sciences Centre for most all of my career, working with adults and pediatric patients.

ONA, if you don't know, is the largest nursing union in Canada. We represent over 65,000 registered nurses and allied health professionals and more than 14,000 nursing student affiliates. We provide care in Ontario's hospitals, long-term-care facilities, public health units, the community and industry.

Today I'll be highlighting four areas from our submission that you have before you and that the standing committee is reviewing, I hope: in regard to the Ambulance Act, the Health Protection and Promotion Act, the new proposed Oversight of Health Facilities and Devices Act, and the Long-Term Care Homes Act.

First I want to express that we have a great deal of disappointment in regard to the lack of consultation with us regarding the proposed amendments contained in the 10 schedules that comprise this omnibus Bill 160. We represent front-line health care professionals providing direct patient care in sectors related to these proposed amendments. We believe our advice and guidance could have been beneficial and that this is a flawed process, we

believe, resulting in flawed legislation. ONA has concerns with six out of the 10 schedules in Bill 160, but I'm going to speak to four.

Let's start with schedule 1, the Ambulance Act. The minister's operational or policy directive may include "conveyance of persons by ambulance to destinations other than hospitals," which is not defined. If there were specific destinations other than hospitals that this power is intended to cover that do appear to be in the public interest, then the minister should specify what these destinations are up front in legislation so that everyone is clear. Otherwise, the amendment appears to leave it wide open to transfer patients to private, for-profit locations. There are also issues of patient choice and holds liability for the transfer of patients. Finally, we oppose the minister's regulation-making authority exemption from the act, especially in the case of unspecified pilot projects.

We'll now turn to the Health Protection and Promotion Act. We're concerned in regard to the proposed amendment in section 7(2) to amend the list of specified regulated health professionals—physicians, nurses and pharmacists—who have the duty to report reactions related to the administration of immunizing agents by adding "or a prescribed person."

Regulated health professionals are listed as having the duty to report a reaction to ensure the safety of the public because they are able to make the assessment regarding the reaction to an immunizing agent. If there are additional regulated health professionals whom the minister is considering to prescribe this duty, then the regulated health professionals should be specified in legislation—or amend it to specify "or prescribed regulated health professional."

Third, we have concerns related to the repeal of the Private Hospitals Act and Independent Health Facilities Act, combined with the proposed new act, which appears to facilitate the expansion of for-profit clinics. It does not provide an enhanced inspection regime to regulate safe, quality care. There was no consultation whatsoever with ONA in relation to this schedule before it was tabled. We believe the repeal of the Public Hospitals Act means that the ban on granting further licences for private hospitals is now eliminated and the minister's powers to regulate licences for private hospitals has been removed. Independent health facilities are now renamed "community health facilities" under the new act, but not defined in legislation.

Any person may apply for a licence to operate a community health facility. Whether or not the executive officer appointed to oversee the process has requested application, a new appointed, unelected executive officer position now has the authority for the regulation of private health facilities, including private hospitals, that previously rested with the minister.

Prohibitions about charging facility fees have been removed. Specific provisions regarding safety and quality standards, the complaint process, an inspection body and enforcement discretion are to be provided, if any, in regulation only. In fact, the inspecting bodies to be designated in regulations are charged with developing the safety and quality standards.

The proposed framework for quality assurance programs for private clinics, we understand, will likely continue to be managed by assessments and inspections conducted by the same professional college as before. We note that there have been a number of documented challenges reported in the media with this quality assessment framework that's currently in place.

Our final area we want to talk about is in regard to schedule 9. The new definition of "confine" being added to section 2(1) in the act, which will only be defined in regulation, raises a number of concerns for ONA and our members who provide care in long-term-care homes. While ONA supports limitations on confining residents and the rights of residents, we are concerned that appropriate levels of staffing to care for high-needs residents are not in place. At the same time, the definition of a secure unit in subsection 2(1) is repealed, although apparently not eliminated. Over 90% have cognitive impairments and for 30% the impairment is severe in our long-term-care homes.

1650

We also know that skilled care providers have a significant impact on resident well-being, but many long-term-care facilities have only one registered nurse on staff for up to 200 residents.

The Chair (Mr. Grant Crack): Okay. Thank you very much. I have to cut you off there. We'll start at the NDP. Sorry. You're at six minutes; I gave you an extra minute.

Madame Gélinas.

M^me^ France Gélinas: Thank you so much. I will take it in a backwards order. The first one is in schedule 10, where, basically, the retirement home would be allowed to confine and restrain. Can you ever think of a way to do this that would be safe, or should we not do that at all?

Ms. Vicki McKenna: Well, I'll tell you that we were quite surprised to learn the number of retirement homes that currently have secure units. Knowing that there is no regulation in regard to skilled care providers and regulated health care providers in retirement homes causes us a great deal of anxiety. To think about the fact that we have no statutory regulated skill provider ratios or care hours defined that are tied to confinement and then—these restrictions, we believe, will only leave residents and, quite frankly, staff at risk.

We go back to the Casa Verde recommendations of many years ago. None of those recommendations, actually, have ever really come into place. Particularly, what Casa Verde recommendations said about this—about skilled care providers, about confinement—this piece of legislation as it stands now really is the polar opposite of the recommendations that came from that inquest.

We believe that we need to protect our residents, and, certainly, we need to have the skilled providers. We know people do better when they have more regulated health professionals at the bedside working with people who have cognitive issues, and this legislation certainly

does not seem to put into place anything to provide for or protect those residents.

M^me^ France Gélinas: When we look at calling independent health facilities and out-of-hospital premises "community health facilities," do you see any risk of confusion by the public that a private, for-profit clinic will become a community health facility?

Ms. Vicki McKenna: Absolutely. Although it's a nice-sounding title, we believe it's vague and believe that it certainly could be misinterpreted; people won't understand what it is. They will think it's publicly funded. The removal of the additional charges in that legislation—maybe it will be in regulation, maybe it won't. We believe those are fundamental things about licensing and about additional charges that Ontarians may be faced with if they enter these clinics. I don't believe that they will know what they're facing when they walk in there without the legislation clearly in place that defines what it is.

M^me^ France Gélinas: I agree.

When we talk about the independent health facilities, would you be comfortable continuing to call them that way rather than moving to "community health facilities"?

Ms. Vicki McKenna: I actually hadn't thought so much about the title until I saw the change, to be really honest with you. I don't know if Lawrence or Bev have thought about that—something that is clearer.

M^me^ France Gélinas: They're private clinics.

The Chair (Mr. Grant Crack): If not, the time is up. It's okay. I'll have to move—I apologize—over to Ms. Wong.

Ms. Soo Wong: I should declare, myself, Mr. Chair, that I was a member of ONA for many years, in my nursing career.

I want to go back to your written submission. First of all, it was very well done.

I want to go back to your recommendation dealing with schedule 10, dealing with the retirement home piece. You focus specifically on dealing with the definition of "confinement." With the proposed legislation, if passed, there is lots of stuff in terms of enhancement of enforcement.

Right now, there's a whole slew of unregulated retirement homes that have not been inspected, as you can imagine, and I know that for a fact, coming from Toronto.

My question to you is, as a member of ONA, with this amendment of the legislation, we're going to provide more mandatory inspections for both regulated and unregulated retirement homes. In your opinion as ONA, is that a good thing in terms of protection?

Ms. Vicki McKenna: I didn't see that—more inspections. Lawrence?

Mr. Lawrence Walter: Yes, what we're really calling for here is the repealing of the amendments related to confining. The rest of schedule 10 we think can proceed if there is further enforcement.

Our issues are around confining. We don't think there are any circumstances where residents in a retirement home should be actually confined, because there aren't sufficient regulated health professionals to provide that care. They shouldn't be confined. If there are limitations around confinement, there's a need for even further regulated health professionals to provide that care, and there's nothing in the legislation. As we mentioned earlier, there was no consultation regarding these amendments. We would have provided that guidance had the consultations happened before the legislation was tabled.

Ms. Soo Wong: Okay. Because time is constrained, I want to ask you with respect to the piece about the designation of community health facilities. I know that the minister is interested to have more oversight of these six private hospitals—because there are only six. I want to make sure that you understand that the government is committed to universal health care. The government is very interested to have more oversight on these six facilities, because some of them are chronic hospitals; let's call it the way it is. We've got to make sure they have more oversight, not less. I guess we're playing with names and the name of the private care hospital, to call it a community care facility.

My question to you, as the first president of ONA: Do you believe that the oversight piece is important to make sure every facility is being protected?

Ms. Vicki McKenna: We don't believe that the legislation says that. We don't read that into it. It's like the gate is wide open, is how we read that legislation when we looked at it—not more oversight but actually less. Handing over the authority, really, to an executive director instead of the oversight of the ministry: This isn't a government official; this is an appointed person, from what we read in the legislation. We certainly agree that there should be more oversight, more inspections, but that isn't what we believe this legislation says at all. In fact, it's opposite to what you're saying.

The Chair (Mr. Grant Crack): Thank you very much; appreciate that.

We'll go to Ms. Munro from the official opposition.

Mrs. Julia Munro: I'm looking at page 9 of your document. The first sentence says, "Moving additional procedures out of hospitals and into private for-profit clinics is not in the best interests of safe, quality care for our patients. For that reason alone, such clinics must be limited and must be highly regulated." I'm just wondering if you could explain what the difference in regulation would be that you're referencing here that would be necessary because it was a for-profit clinic.

Ms. Vicki McKenna: Our position on for-profit institutions is that the health care dollars that are spent are funnelled there. There is a piece of those dollars that is carved out for profit. In not-for-profit facilities, that bit of money stays internal—it might be staff; it might be supplies; it might be the environment—for whatever it's spent on.

We believe that for-profit organizations need high regulation and frequent inspection. We believe that it's not that these aren't good people; it's just that their philosophy is not the philosophy of publicly funded, publicly administered health care. That's what we stand

by forever. We don't believe that more privatization of our health care system is in the best interests of Ontarians, certainly not patients or of our members.

Mrs. Julia Munro: Can you give me an example of where would be the focus of the regulation? I just wondered if you could give a description of what that would look like, in comparison to a public one.

1700

Ms. Vicki McKenna: Certainly, what we don't see is the structure of the inspection, what the specific guidelines and expectations are. The legislation does not define clearly enough the requirements that, we believe, are contained in other legislation in regard to the health and safety of workers and the safety of patients. Those are the things that are missing here.

Mrs. Julia Munro: That really answers the question that I had. Thanks.

Ms. Vicki McKenna: Okay, thank you.

The Chair (Mr. Grant Crack): I would like to thank the three of you for coming before committee this afternoon. It's much appreciated.

GS1 CANADA

The Chair (Mr. Grant Crack): Next we have GS1 Canada: Alicia Duval, senior vice-president, industry relations. We welcome you, Ms. Duval. You have five minutes for your presentation, followed by up to nine minutes of questioning. The floor is yours.

Ms. Alicia Duval: Good evening. Thank you for your invitation to present. I represent GS1 Canada, a member of a global, neutral, not-for-profit, supply chain standards organization. We're represented in 112 countries around the world, with over one million members. GS1 standards are used in more than six billion transactions each day, and you know us best for the bar code.

Health care has much to gain by the adoption of global standards. Almost every major sector has universally adopted global supply chain standards and processes to ensure consumer safety, quality and visibility. These major sectors include grocery, general merchandise, retail pharmacy and foodservice. So when you hear that beep at the cash register, you can think of today's presentation. We enable that around the globe.

Medical error is now the third leading cause of death in Canada, the US and the United Kingdom. Fundamentally, adverse events and errors in health care are an outcome of an underdeveloped supply chain. Transforming the supply chain in health care could make it difficult, if not impossible, for errors to occur. Visibility within and across health systems enables all stakeholders to deliver safe, effective and accountable care that contributes to health wellness and quality of life for Canadians.

Most would be shocked to learn that it's easier to trace and recall a bottle of water from a grocery store than a faulty medical device in our health system. The bottle of water is safer because it is labelled by the manufacturer with a single GS1 bar code, and vital product data and images are standardized and centrally stored in a national product registry. The development of the registry was initially funded by Innovation, Science and Economic Development Canada.

Today, crucial information about health products is primarily managed manually and relabelled with proprietary codes, resulting in fragmented supply chain systems. By adopting global standards called for by the Ontario Healthcare Sector Supply Chain Strategy Expert Panel, we can enable product traceability in the event of a recall, or identification of patients who are using or have these products implanted.

We also enhance the capacity to accurately analyze data to inform us about quality and safety of products and to prevent medical errors. A well-developed supply chain creates visibility needed to support clinician teams to deliver health services effectively and safely.

Over 40 years ago, the grocery sector faced similar challenges to ensure safety, quality and accountability. Through the adoption of GS1 standards, the grocery sector saw the following results: They saved $17 billion a year; a 21% shorter lead time for warehouse operations; a 42% lower cost at distribution centres, and 32% lower stock-outs for retailers.

At the recent Global GS1 Healthcare Conference in Chicago, the World Health Innovation Network presented preliminary research evidence from Canada, the US and the UK that determined how supply chain transformation can advance health system performance. The findings were as follows:

Alberta Health Services: By consolidating contracts and standardizing pricing, they immediately saved $80 million, and have so far reported $261 million in optimizing inventory processes.

The NHS: Six health trusts who implemented the Scan4Safety program have reported an expected £48 million in savings from inventory optimization.

Mercyhealth in the US: Three of the 45 hospitals have reported $55 million in savings in inventory optimizations as well as charge capture savings of $13 million.

All three cases identified the need for both top-down leadership and supply chain champions to drive implementation. Large-scale change was driven by senior levels of government, and implementation strategies were advanced by individuals who understood the opportunity for impact that supply chain transformation could achieve.

Ontario has already demonstrated leadership to enable the adoption of GS1 standards in health care from the point of manufacture to patient. Through the Ontario Buys program, Ontario provided funding to establish the foundation for implementation readiness in the health sector.

We commend the government of Ontario for demonstrating leadership in incorporating recommendations to adopt the standards within Ontario in the final report established by the Ontario Healthcare Sector Supply Chain Strategy Expert Panel.

The ongoing viability of Ontario's health care system is dependent on its ability to respond to evolving patient

safety priorities. We encourage the committee to ensure that through Bill 160 Ontario is positioned as a global leader in supply chain standards adoption, health care visibility and supply chain management.

I thank you for the opportunity and look forward to questions.

The Chair (Mr. Grant Crack): Thank you very much. We'll start with the government. Mr. Rinaldi.

Mr. Lou Rinaldi: Thank you for being here. Certainly, this brings a different perspective than what we've been hearing all day.

Ms. Alicia Duval: I bet.

Mr. Lou Rinaldi: Now I know, when I go to the grocery store, what happens.

Ms. Alicia Duval: You'll never forget it now.

Mr. Lou Rinaldi: Or pushing the button.

Maybe I missed it; I was intrigued also by the other information that you supplied to us. Do we, as a government, in the health care sector, do any of this now at all, that you know of?

Ms. Alicia Duval: Very little. At this point, within Canada, the Public Health Agency of Canada, without regulation, has recommended the use of bar codes and has put the vaccine information in that same registry I referred to. Where you see it used is on a voluntary basis at this point.

Pharmacy is a little bit further ahead, because retail for pharmacy drove it at the same time as the other sectors. There's a huge foundation of readiness of food service and pharmacy because of other sectors. Medical devices is coming along, mainly because the US FDA does have regulation requiring the bar-coding of medical devices and supplying data that hospitals need in order to do procurement as well as bedside verification that the right patient is getting the right product.

Mr. Lou Rinaldi: Is the province of Alberta the only province in Canada that has embarked—

Ms. Alicia Duval: They, through their consolidation, have consolidated their supply chain and procurement, and they're at the stage now of marrying that to their patients and their clinical care.

The vision—so use our grocery example—from the point of manufacture: Wherever Campbell's soups or Corn Flakes are made, whether it's in North America or across, it has one bar code on it. That's used for sourcing and procurement, it's used for inventory management and it's used for customer relations, so you know that from the cash register. It is also used in recall: If there's a recall, that's the number the manufacturer puts out.

In health care, it's the exact same vision from the point of manufacturing, sourcing, procurement, inventory management—but now we're talking about bedside bar code scanning. "Is this the right product, and is this the right patient? Is that number now in my medical record, so if it's recalled, and it's a hip implant, irrespective of it was obsolete, how do we find it in the system automatically?"

I brought with me what happens today. This is a great example, where you have a hospital doing automation, and that's great news. They are doing bar-coding. You have a manufacturer that's put a bar code on. This manual sticker is from the distributor—new number. This sticker is done by the hospital. That little diamond tells the nurse, "Scan this one."

It's great news that hospitals are moving to automation to support the clinicians, to ensure that this product hasn't been recalled and to get it in the patient record, but we've just lost our visibility. We've lost our ability to do analytics, because everyone has called it something different. If the manufacturer posts this number to say, "This is the product that has been recalled," everyone's called it something different. So the foundation is not ready in terms of overall adoption. The standards are ready. Grocery—any other sector—would never hire people to relabel. One, they're hiring people; they're investing money. They're investing technology to completely destroy the visibility and traceability that leads to patient safety and, of course, economic issues as well.

1710

The Chair (Mr. Grant Crack): We'll move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here. You've raised some very valid points. When you can use automation and bar-coding, it certainly does work. I have a pharmacy, and we've been doing that for a long time. My concern is that there are so many hospitals out there that are still doing manual inventory control when they have the technology in their hospitals—to use technology, and they're not. In fact, we have an expert panel report that said they could save $500 million a year if they actually flicked the switch and changed to automation. I see that as a barrier to moving forward, to having proper bar-coding through our health care system. What are your thoughts on that?

Ms. Alicia Duval: I think it's a journey. I don't think there are many sectors or many initiatives where things turned over overnight. Of course things happen quicker with regulation, when you "shall" and people pay attention and make that happen.

But to your point, there are huge investments happening today within health care, but there's no one overseeing to ask the fundamental question: When you put that system in, are you using proprietary numbers or are you going with the global standard? Those are the foundational decisions that the UK, Australia, even Alberta—making them requirements so those foundational elements are there.

Then you have situations where hospitals might be starting an initiative. That's so ideal to do it at the starting point compared to others who may need to do it integrated into existing systems. It's not really a black-and-white answer. Sometimes it's scenario-based, but we have found—and that's why we've cited the research that's coming out of countries where government have taken leadership—the implementation has happened quicker and the return on investments is happening at anywhere between a 1-to-4 to a 1-to-8 investment: $1 of investment is getting anywhere from $4 to $8. Those are statistics that these governments are sharing openly.

Dr. Anne Snowdon, the research that you have in your kit there, that is her initial research. Right now, she is starting the business case. So the numbers I cited today were the preliminary results. By early 2018, we'll have the final results. That's coming straight from those health organizations that took the investment to make that happen.

Mr. Jeff Yurek: We just need the leadership to make this happen.

Ms. Alicia Duval: Absolutely. That was the key point of differentiation. In Canada, we're doing it on a voluntary basis. The countries that I just cited have their governments supporting and giving the direction and the policy to make it happen.

The Chair (Mr. Grant Crack): We'll move to Madame Gélinas from the NDP.

M^me^ France Gélinas: That was fascinating. I knew nothing about any of what you were talking about, so it was really, really interesting to try to wrap my head around what you're talking about. My first question is that we're talking about Bill 160, so do you see an opportunity for us to put something in there that would bring the leadership forward so that we start to look at this with a vision of success?

Ms. Alicia Duval: Absolutely. When we talk about quality and accountability, it has to come from the top. How do we enhance quality and how do we make decision-makers accountable to make sure their foundation enables thing like supply chain? In the presentation I just mentioned from Dr. Snowdon, she cited Dr. Ross Baker. If you know his research, 10 years ago he did a patient safety analysis in Canada. He repeated it last year. The numbers didn't change. So, foundationally, whatever we're doing has not been effective.

What we are saying is health care has been slow to adopt what other sectors have done to get the foundation right. You can do analytics to compare products, to do spend analytics, to do automation without having to invest in relabelling, and once we have that set, we can think about the administration and the safety in the clinical.

We also examined the nursing population in clinical care. Would they support or resist? They're absolutely embracing this. If you can do any element to take away risk, some of the mistakes you have are: like name; like images; a light blue versus a dark blue bottle; one is pediatric, one is adult. You feel horrible for those who come in and make a mistake. A simple scan could say "That is not what that doctor prescribed. Stop." Those interventions are opportunities to avoid the risk to patients.

M^me^ France Gélinas: So where in Bill 160 do you see an opportunity for us to sneak that in?

Ms. Alicia Duval: I would say within the accountability and strengthening quality component.

M^me^ France Gélinas: I have a minute left. "Alberta did a consolidating contract and standardizing contract pricing immediately." I have no idea what that means.

Ms. Alicia Duval: In Alberta, when they consolidated their health care system, they also consolidated their supply chain. They went from every hospital and every region managing their procurement to managing contracts at Alberta Health Services. That gave them centralized control and greater visibility to do better inventory controls.

When you hear physicians and nurses talk about their inventory rooms, sometimes things they go for are not there and at other times there are huge amounts there. How do we, like other sectors, do just-in-time delivery? Those types of statistics relate to having visibility of what we are buying, where it is—especially home care—where it's moving to and from, what we have and what is becoming obsolete so we can either use it before it gets thrown out or unfortunately use it within a patient. It's that level of visibility into the movement and procurement of product.

The Chair (Mr. Grant Crack): Thank you kindly for coming before committee and sharing with us this afternoon; much appreciated.

Ms. Alicia Duval: Thank you.

CANADIAN CYSTIC FIBROSIS TREATMENT SOCIETY

The Chair (Mr. Grant Crack): Next we have the Canadian Cystic Fibrosis Treatment Society. We have Chris MacLeod with us, who is the national chair. We welcome you, sir.

Mr. Chris MacLeod: Thank you.

The Chair (Mr. Grant Crack): Are you hot? Is it hot in here?

Mr. Chris MacLeod: A little, but that's okay. There are a lot of people, and it has been a long day for everyone, I'm sure.

The Chair (Mr. Grant Crack): It's a good day.

You have up to five minutes for your presentation, followed by nine minutes of questioning. The floor is yours. Welcome.

Mr. Chris MacLeod: Okay. Thank you. I'll try and be quick.

My name is Chris MacLeod and I am an adult with cystic fibrosis. When I was born in 1969, life expectancy was 6; I think it's now in the early 50s—51 or 52.

In 2012, I had a health care crisis. My lung function fell below 30. I'd been in hospital maybe a dozen times over the years. I was in hospital for four of the six months between June and November 2012. My doctor at St. Mike's said—I'm going to get into the macro picture but I wanted to give some personal context—"Chris: good news and bad. There's a drug available"—it was Kalydeco; some of you may have heard of it—"however, it is not yet allowed into the country."

Long story short: I ended up on the drug. Ten days after getting on the drug in 2012 my lung function was up to 60%—FVC 1, forced vital capacity in one second—my weight went from lower than 150 to about 175—it's getting to be a little too much now; about 180—and I was back to work full-time. So I set up the CF Treatment Society to advocate for CF patients who need life-

sustaining medication because it is a dog's breakfast if you are a patient trying to access life-sustaining medication.

That's what I'd like to dive into now: Transparency and accountability—I put the two together—as it relates to patients.

I'm a lawyer by day. I have gone through the bill. Conspicuous in its absence, in my respectful submission, is any attempt to deal with the white elephant in the room from the perspective of a patient who needs life-sustaining medication: How government deals with itself and allows patients to interact with it in terms of deciding what drugs are going to be added to the formulary. Kalydeco is now on the formulary.

There is a new drug, Orkambi, and I'm going to use this as an example to show the challenges we patients have—it's not just CF. I always find—and we do it in law—a case study. Cases is how we build precedents.

Let's look at Orkambi as a for-instance. Right now, Canada stands alone in the industrialized world in not even negotiating a price for this drug. Granted, these biologics are expensive; I think the Kalydeco sticker price was 250 grand a year, or thereabouts. I'm on it through my private insurance. Many of us—and I've seen various numbers, whether it's 45% to 50% of Canadians—have private insurance. I'm on Kalydeco by private insurance. The sliver of people who don't have private health insurance for drugs are the ones who are left behind. Health transfer agreements—ours in Canada would be CADTH: 65 countries have them.

1720

The pan-Canadian Pharmaceutical Alliance—in principle, having experts that are independent guide us makes sense; no dispute. Having all provinces come together to negotiate pricing makes sense. The devil is in the details. The unintended consequence of this system—and believe me, over the past five years, I've tried to reach out and speak to different politicians and ministers about this. Politicians will say, "Well, we really have to defer to CADTH, because I'm not an expert in health care. So I defer to CADTH." CADTH makes a recommendation to the pan-Canadian Pharmaceutical Alliance, which will decide, not bound by that recommendation, but I'll tell you, if CADTH doesn't recommend it, the PCPHA will not negotiate it.

In 2016, the drug company filed an application at CADTH. CADTH, on Orkambi, said, "You know what? The price is too high. We don't recommend you negotiate unless there's a lower price." They don't say that it's not effective. Right now, since 2016, there has been no negotiation on this drug. Patients can't go to their elected officials, or we try and they will immediately say, "Well, it has to go through CADTH." So in the interim, while Americans, French, Germans—go around the board—either have access to the drug—by the way, if you have private insurance, you do have access in Canada. I'm talking about those poor individuals who don't have private insurance and are left behind.

Right now, the PCPHA will not negotiate. Just to catch you up to speed, the drug companies put an unsolicited offer out. I don't know what it is, but I would gather it's a lower price.

Where patients are frustrated on transparency and accountability—CADTH makes a recommendation to lower the price. Well, if you're not going to negotiate—I work in the private sector. You want a lower price? You pick up the phone and you negotiate. That's how you get a lower price. So, to say right now—and this has been going on for months. We're now going into 2018. In 2016, the drug was on the market, or roughly around that mark, by Health Canada. CF patients—and I will tell you this: A patient will die. I know children right now. It's the genetic mutation or it's sick kids, lung function in the 60s, and we've got a government that won't even negotiate.

So let's just talk about transparency and accountability—

The Chair (Mr. Grant Crack): I'm going to have to cut you off. I gave you an extra minute. I apologize.

Mr. Chris MacLeod: Okay. No, that's fine.

The Chair (Mr. Grant Crack): We'll start with the PCs.

Mr. Jeff Yurek: I'll let you finish in one second. Maybe you can comment. We ask in the House about rare disease drug coverage and we hear that the government has fixed the problem. So maybe you can comment and talk about that.

Mr. Chris MacLeod: I don't know how it's possible that it's fixed, because—well, maybe I'm behind. I know that there was a report that was going to come out from the Minister of Health's office where there was an independent group. Has that report come out?

Mr. Jeff Yurek: I haven't seen it, no.

Mr. Chris MacLeod: Okay. I haven't seen it. We need to address the conflict of interest. In CADTH, the payers, ADMs, sit on the board. It's staffed primarily from Ministry of Health—many in Ontario. So that's how CADTH is staffed. The pan-Canadian pricing alliance—our executive officer is the chair. So the province has staffed and managed and, by the way, funded CADTH, which is our independent body. We need to be able to address the inherent conflict that is found in that system. We go to our politicians and they say that it's CADTH. CADTH has the ADMs of various provinces and is funded by it.

While there is good work to be done by the HTA, the unintended consequence in this case is that great deference is now given—and by the way, there is no subject matter expertise in a condition like CF on CADTH, or many other rare diseases. And rare diseases, to answer your question, Mr. Yurek, would be—bulk price buying is harder when it's a rare disease. You might be buying 500 drugs for 500 patients, as opposed to 20,000 or 50,000.

The principle of HTA? Great. The principle of bulk negotiating and buying? Great. But we must deal with this. Time is of the essence. While I know it's not directly dealt with in Bill 160, I can't help but appear and speak to you, if we're talking about accountability for

patients. For CF patients, the white elephant in the room is, how do we ensure that negotiations occur so that those people who don't have private insurance have access?

Mr. Jeff Yurek: I appreciate you being here, because from what I've seen in this bill and from talking to ministries, patients weren't really consulted on the creation of this legislation. They missed out. We hear OHIP+ saying they're covering rare disease drugs, but obviously they're only covering a select few, as opposed to Orkambi etc. It's just not happening. So I'm glad you're here to dispel those myths that are floating out there in the general public.

The Chair (Mr. Grant Crack): Madame Gélinas.

M^me^ France Gélinas: If you are now the Minister of Health, and you want to do good by the people who have cystic fibrosis or any other disease that is treated by biologics and all of those expensive drugs, how would you like it to work?

Mr. Chris MacLeod: I think we need to empower patients and their doctors as the decision-makers. Again, as an example, 42 CF clinics across the country filed a submission to CADTH and said, "Here's the start criteria and the stop criteria for this drug, so that it's not being used and not being paid for if it's not working."

I think we need to fully acknowledge that we have a two-tiered system when it comes to drug coverage: We have those who have private insurance and those who have access to the public formulary.

I'm a little concerned with the idea of OHIP+—not that I don't want everyone to have access to drugs if they need it. But I've had the benefit of conversations about what people in our bureaucracy in Ontario deal with. They say, "Chris, we have a limited pool of money." Granted. I'm happy to talk about what drugs to delist. I'm happy to talk about what not to spend money on. We need to be cautious that—if we have people covered by private insurance, then let's not cover them; they're already looked after. We do have limited dollars, and I'm sensitive to that. When I can go from four litres of oxygen a minute to back to work and now presenting to you here today, that's a drug that we should make sure people have access to. When we have people working, we can get them into private plans of insurance.

Let's try to work with the private sector to increase the number of people who have private insurance. I think we need to have some closed-door discussions that bring in private sector insurance companies and private business, and ask, "How do we expand the reach of private insurance?" Some of the private insurance companies have had phenomenal years of growth despite biologics coming on the market.

So I would talk about where we're currently spending money in the health envelope, where we can cut back, what we need to focus on from the patient perspective. I know it's always easy to sit on the outside and say, "Well, just fund"—and I don't propose to do that. As I've said, I'd be happy to have a conversation about what to delist, if people wanted to have it.

M^me^ France Gélinas: Your particular drug plan never put a cap on—that you're not allowed to spend more than $50,000 a year or $100,000 in your lifetime, any of that?

Mr. Chris MacLeod: No, but that's because I run my own business with two great business partners. We have a law firm. We've got 23 people working with us, and a top priority is that we have great private health insurance coverage for everyone in our organization. When I sit down to negotiate every year, I specifically make sure that we don't have caps. Touch wood, to date—we have a couple of other people in my office who are on expensive drugs, and they're covered, and we don't have a cap.

But I agree: These are real issues. We need to start teaching and empowering the private sector to negotiate in a fulsome way and to look at different options of business coming together to make sure—because the public system can't take it all.

The Chair (Mr. Grant Crack): We'll move to the government. Ms. Vernile.

Ms. Daiene Vernile: Thank you very much, Chris, for coming here and sharing your personal story with us. It's very informative and it helps to guide and direct us as we move forward on this bill. Can I ask you how your health is now?

Mr. Chris MacLeod: Touch wood, it's pretty good. I've got a little bit of a cold, but that's just a football game yesterday.

1730

Ms. Daiene Vernile: Do you continue to take this medication?

Mr. Chris MacLeod: Oh, yes. To be clear, this doesn't cure CF. I take it along with my inhaled antibiotics every day, my digestive enzymes every day. So my treatment regime for CF hasn't shifted. This drug, though, gets you back in the game. I'm not a scientist, but really it takes the genetic defect—in my case, it was the delta 551 gene—and normalizes it so that it can function. I take it twice a day.

It's interesting; the CF gene was discovered at SickKids hospital in 1989, so, really, this is a result of 20 years or more of hard science work. Now, we're seeing the fix, and one of the benefits of these biologics in my personal experience with this drug is that because it normalizes a defect, you don't see as many side effects. It's just making work what didn't, whereas typically with things like prednisone, which I have been on in the past, it creates a lot of mischief because it's trying to end run a problem. That's my layman's explanation.

Ms. Daiene Vernile: You mentioned a couple of medications, and just to bring you up to speed, Orkambi will be covered under OHIP+, and other medications—

Mr. Chris MacLeod: It will?

Ms. Daiene Vernile: This is what my staffer has told me, so this is good news. All of these medications are being looked at. A number of them are being looked at.

You mention that you would delist. What would you delist?

Mr. Chris MacLeod: That's a good question. I would—well, I can tell you right now. You get vitamins

when you go on the drug plan, and I'm not sure you need to. I think it depends—and this is where I defer completely, and I think we have to, to a doctor and their patient.

I'll give you an example: Pulmozyme. I've been on Pulmozyme. There's an alternative, which is a saline solution you can inhale. It's less expensive, and it may be that for some patients, they can look to that, as opposed to Pulmozyme. As a lawyer, I don't have sort of the—what's the word for the manual of drugs—

M^me^ France Gélinas: CPS.

Mr. Chris MacLeod: CPS. Thank you. So I couldn't really go through it, but I would be happy to engage in that discussion, which I've been told—CADTH and the MOH individuals say that nobody ever wants to talk about delisting. So I don't really have a list I can hand you now, but my point is, I'm more than happy to engage in that discussion. I know one of the reasons that the bureaucrats are always saying, "Oh, everybody just wants to talk about what they want on. Nobody will talk about what you want"—I'm happy to talk about what to take off.

The Chair (Mr. Grant Crack): Okay. Thank you very much. We appreciate you, Mr. MacLeod, coming before our committee this afternoon and sharing your thoughts.

Mr. Chris MacLeod: Thank you, Mr. Chair and committee.

The Chair (Mr. Grant Crack): Have a good evening.

ONTARIO ASSOCIATION OF PROFESSIONAL AUDIOLOGY CLINICS

The Chair (Mr. Grant Crack): Next, we have the Ontario Association of Professional Audiology Clinics. We have Mr. Jeffrey Switzer, who is vice-president, and Hish Husein, who is the president, with us today. We welcome the two of you, gentlemen, before committee this afternoon. You have up to five minutes for your presentation. The floor is yours when you're ready.

Dr. Hish Husein: Thanks.

The Chair (Mr. Grant Crack): Just maybe state your names for the record when you're speaking.

Dr. Hish Husein: My name is Hish Husein. I'm the president of the Ontario Association of Professional Audiology Clinics, and this is Jeffrey Switzer, the vice–president. I want to thank Mr. Chair and members of the standing committee for providing our organization with the time so we can give some input into this bill. We're talking about Bill 160.

Just a little background on audiology and audiologists: We are members of the Ontario association, like I said. We are audiologists who own and operate our own private clinics. We're the only clinics who are fully regulated by the College of Audiologists and Speech-Language Pathologists of Ontario; that's CASLPO. We have a minimum of six years of training with a master's degree, and some of us have doctoral degrees, like myself. We can identify, assess and manage hearing loss and other auditory disorders in people of all ages. We can dispense hearing aids and other assistive listening devices, and we are legally allowed to prescribe under the RHPA.

Our focus today is on the Health Sector Payment Transparency Act. To be clear, our organization supports the disclosure of payments and transfer of value by manufacturers of all medical devices, including hearing aids, to all who dispense them. I emphasize the word "all." Bill 160 is well intentioned. However, we have concerns that this bill will not capture transfers of value to all who dispense hearing aids. As such, this bill would create a significant unlevel playing field in the hearing aid dispensing sector.

To clarify, in Ontario today, if a person needs a hearing aid, they can obtain one in three ways: They can go to a regulated audiologist and get a prescription from their clinic; they can get a prescription from a physician or an ENT specialist, which can then be taken to an unregulated dispensary; or they can go directly through to an unregulated multi-retail big-box outlet selling hearing aids. This could be a parent company in which the hearing aid manufacturing sector is a public and privately held corporation, or those owned by other health care and non-health-care professionals.

I am certain all of you are familiar with free hearing tests being promoted at your local grocery store or favourite big-box discount store. You may be also familiar with radio and TV ads offering the same. Unlike our clinics, which are audiologist-owned, these other establishments which conduct hearing tests and sell hearing aids are not regulated by the College of Audiologists and Speech-Language Pathologists of Ontario.

In 2012, according to our college, 626 audiologists were practising in Ontario. Of those, only 13% were owner-operator. That means up to 87% of the remaining practising audiologists would not be captured by Bill 160 because they are not owners of the clinics but employees of these unregulated sites. In other words, transfers of values from hearing aid manufacturers are made to the corporate entity that owns the unregulated hearing aid dispensary and not to the health professionals themselves. This is how they are left out of the bill and thus would create an unlevel playing field.

There is concern from the taxpayer point of view as well. All hearing aid dispensaries provide hearing aids that are reimbursed by the Ministry of Health and Long-Term Care through the Assistive Devices Program. Up to 75% of the cost of the hearing aid is reimbursed to the patient. ADP listed a total of 864 hearing aid vendors registered in Ontario for 2017. All registered vendors have a financial relationship with hearing aid manufacturers. However, only 81 vendors, or 9.4% of audiologist-owned clinics, would be captured under Bill 160.

If one of the purposes of the proposed Health Sector Payment Transparency Act is to better understand transfers of value and how they may influence overutilization or create bias, they would be missing out on 90% of the registered vendors. Meanwhile, audiologist-owned and

regulated clinics would come under increased scrutiny. This may diminish their relationships with manufacturers, patients and the ADP program, while all other arrangements between manufacturers and vendors would remain in the dark.

This bill exposes and exacerbates the wild west of hearing aid device dispensing in Ontario. Hearing aids are the only medical device that require a prescription from a regulated health professional but do not require a regulated health professional to dispense. For drugs and eyeglasses, both the prescription and dispensing are controlled acts and must be conducted by a health professional authorized by the RHPA. Furthermore, the diagnostic hearing test can also be performed by anyone because it's not a controlled act.

There are significant regulatory breaks in this patient continuum, which is how corporations have been able to capitalize and become so involved in the hearing aid sector.

The Chair (Mr. Grant Crack): Final wrap-up, please.

Dr. Hish Husein: Hearing is an important part of your overall health. No one wants to go through life without the capacity to hear. Audiologists are trained for a minimum of six years. We need to address this regulatory issue. We have two options to recommend.

The Chair (Mr. Grant Crack): Okay, thank you very much. We'll move to questioning. Ms. Wong.

Ms. Soo Wong: Thank you very much for your presentation. I just want to get some clarity, because you're not the only group to come before this committee this afternoon asking that the owners and the operators be regulated by your sector. Am I correct?

Dr. Hish Husein: That's correct.

1740

Ms. Soo Wong: Okay. Are other provinces doing the same?

Dr. Hish Husein: In some provinces, I believe the vendor is controlled as well. I can't be specific because I haven't looked into that data yet.

Ms. Soo Wong: Okay. The other piece here is that I sense that you want more regulations. The fact that you're presenting to the committee that the hearing aid devices right now, the diagnostic piece and the big box coming in—I want to hear from you in terms of patient safety, because I'm not hearing that. Show me in your presentation—or maybe a follow-up, Mr. Chair. Support your document in terms of evidence-based, because I want to hear about patient safety. How do we ensure that if we do what you're recommending, it's going to improve patient outcomes and it's going to improve patient safety? I want to hear that.

Dr. Hish Husein: Okay. Well, I'm sure the Regulated Health Professions Act went through all of this when they regulated us and allowed us to prescribe the hearing device. They looked at all of the safety issues and it was believed at the time that hearing aids should be prescribed. So we can prescribe the device, but unfortunately, now we can't—

Mr. Jeffrey Switzer: It's not controlled enough.

Dr. Hish Husein: Yes, it's not controlled at the dispensing end and it's not controlled by who can vend it. So the problem is, the way the system is right now, you can totally bypass a regulated health practitioner to get the hearing device. There are no rules or regulations checking up on that. And to acquire the ADP funding, the Assistive Devices Program funding, all you require is the signature from a physician or an audiologist. The problem with that is that if you present a form to any physician out there, they'll sign it without knowing what the correct prescription is for the hearing aid.

Ms. Soo Wong: Okay. Thank you.

The Chair (Mr. Grant Crack): We shall move over to the official opposition, Mr. Jeff Yurek.

Mr. Jeff Yurek: Just further on this, if the entire hearing aid industry isn't regulated, you at least want the—

Dr. Hish Husein: We want a level playing field.

Mr. Jeff Yurek: You want the transparency of payments. You want them to be included in any payments that are made from manufacturers to the businesses outside the—you want to make sure that that, at least, is included, as opposed to regulating the whole field.

Dr. Hish Husein: That's correct.

Mr. Jeff Yurek: Okay. I don't know—can you get hearing aids online from outside the province and stuff?

Dr. Hish Husein: Theoretically, you can order a hearing aid online. You cannot go through the Assistive Devices Program, obviously.

Mr. Jeff Yurek: So you'd have to pay the full price?

Dr. Hish Husein: Yes. But according to the RHPA, the obtaining of such a device is illegal. You need a prescription. So I don't know if that's possible.

Mr. Jeff Yurek: Okay. So the college should cover those situations, if they get notified of it.

Dr. Hish Husein: If someone reports the matter to the college, they will try to go after the owner of the Internet site to see if the regulation can be enforced. But as you know, with the Internet, it's very difficult to track down.

Mr. Jeff Yurek: So this bill, as it's turning out, it's going to be a large task to ensure that all these different—

Dr. Hish Husein: Yes. The only people that will be affected are the privately owned clinics. All the rest are going to have—

Mr. Jeffrey Switzer: Privately owned audiology clinics.

Dr. Hish Husein: Privately owned audiology clinics, yes. All the rest are going to escape this bill.

Mr. Jeff Yurek: And has the ministry been in touch with you to discuss this further, outside of the bill?

Dr. Hish Husein: We have had meetings with the ministry, and it's a work in progress.

Mr. Jeff Yurek: A work in progress. Everything is a work in progress.

Dr. Hish Husein: Yes.

Mr. Jeff Yurek: Okay. Thank you very much.

The Chair (Mr. Grant Crack): We'll move to the third party. Madame Gélinas.

M^me^ France Gélinas: Thank you for coming. You really showed us a side that I didn't know even existed. Are there other jurisdictions where diagnostic hearing tests and dispensing of a hearing aid is a controlled act?

Dr. Hish Husein: Are you talking outside of Canada?

M^me^ France Gélinas: Outside of Ontario—or anywhere you know.

Dr. Hish Husein: I'm not sure about the provinces, but there are places outside of Canada that do have that.

M^me^ France Gélinas: So would you say that it's pretty standard practice that in other provinces, also, the diagnostic hearing test and the dispensing of the hearing aid is done the same way? Does the Wild West that we have in Ontario exist in other provinces as well?

Dr. Hish Husein: Our province is unique in the fact that unregulated people, as well as the regulated people, can sell hearing aids.

M^me^ France Gélinas: Sell, as in dispense?

Dr. Hish Husein: In the other provinces, there are no unregulated; they're in the same college. The issue is that we want a level playing field. Back in 2008, I was at the HPRAC meetings, and it was recommended that the hearing instrument dispensers and specialists in Ontario be part of our college. That was never implemented.

M^me^ France Gélinas: HPRAC made the recommendation that they be included in the college, but it was never acted upon?

Dr. Hish Husein: Yes, that is correct. That was never acted upon.

M^me^ France Gélinas: Okay. For now, you want to make sure that if you dispense, it doesn't matter if you are an audiologist or anybody else, you will have to show transfer of value and you will have to show how much.

Dr. Hish Husein: That's right. That's correct.

M^me^ France Gélinas: Except that you won't capture the manufacturer—

Dr. Hish Husein: No, we will still miss the manufacturer. There is going to be a small portion that's missing, unless we can come up with a solution, right?

M^me^ France Gélinas: Okay. Are there many manufacturers who own their own retail outlets?

Dr. Hish Husein: Yes.

M^me^ France Gélinas: There are?

Dr. Hish Husein: In the majority of the bigger chains that are coming up now, one single entity owns the manufacturer and owns the—

M^me^ France Gélinas: Dispensing?

Dr. Hish Husein: —the dispensing, yes.

M^me^ France Gélinas: When a person is referred to an audiologist—

Dr. Hish Husein: We don't require referral, but in the event—

M^me^ France Gélinas: Okay. When a person goes, are your services covered, or do people have to pay?

Dr. Hish Husein: No, we are not covered.

M^me^ France Gélinas: But if the person is referred to a physician or an ENT, then the service is covered?

Dr. Hish Husein: That's correct. We also had a proposal where we showed that we can save the ministry some money with regard to OHIP billings. But that's another work in progress.

M^me^ France Gélinas: Okay. You have many.

Right now, if they go to an audiologist and have their test done there, they have to pay for it.

Dr. Hish Husein: That's correct.

M^me^ France Gélinas: Then you do—

Dr. Hish Husein: And we're doing—sorry—a diagnostic assessment, not a free hearing test. It's a very thorough exam.

M^me^ France Gélinas: Okay. Then you could do the prescription and do the dispensing of the hearing aid and you get reimbursed for all of the steps that you've done by the patients directly, and then the patients bill ADP for up to 500 bucks and 25% of their hearing aid.

Dr. Hish Husein: That's correct.

M^me^ France Gélinas: If they go through a different provider, then some of those costs don't apply, because—

Dr. Hish Husein: It's bundled into the cost of the hearing aid.

M^me^ France Gélinas: It's bundled into the cost of the hearing aid.

The Chair (Mr. Grant Crack): Thank you very much. Madame Gélinas, I wish I had more time, but we had a little bit.

Gentlemen, thank you very much for coming before committee this afternoon and thank you for sharing your thoughts.

Dr. Hish Husein: Thank you.

The Chair (Mr. Grant Crack): Members of the committee, that concludes the public hearings for today. I just want to thank you for the great work today. We're back here in room 151 on Wednesday at 4 p.m. to continue the public hearings on Bill 160. I look forward to it.

Thanks to the Clerk and everybody who supported us, thanks to everyone who presented and thanks to Kyle. Have a good evening. This meeting is adjourned.

The committee adjourned at 1748.

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